**Student Information**

School Year \_\_\_\_\_\_--\_\_\_\_\_\_

Revised 7/21

Student’s Name (Last, First):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, I acknowledge that it is my responsibility to notify any change in my child’s dietary needs in writing on this form. I give Nutrition Services consent to make modifications to my child’s meals and to speak with the healthcare personnel below to discuss the dietary needs on this form.**  Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which meals will the student eat from the school cafeteria?** (check all that apply)

Breakfast Lunch Snack/Super Snack None **(*if student does not eat from the cafeteria, modifications will not be arranged)***

**REQUIRED: Section Below To Be Completed By A State Licensed Healthcare Professional Only**

Does the child have a **life-threatening food allergy? (check one) No Yes**

Does the child have a **Disability affecting major life activity requiring diet modification? (check one) No Yes**

**Food Allergy/ Food Item Omission**

Can the student consume foods where **the allergen is an ingredient**? (Ex: egg in pasta or milk in pancakes)? **Yes No**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Foods to Omit** | | | **Foods to Substitute** | |
| * Fluid Cow’s Milk | * Dairy Products (for lactose intolerance) |  | * Soy Milk | * Lactose Free Milk |
| * All milk-derived ingredients (for life-threatening milk allergy) | * Wheat/Gluten * Peanuts |  | * Gluten-Free Diet | * Rice, Corn, other Grain |
| * Eggs | * Tree Nuts | | * Equivalent Protein | * Soy Butter |
| * Fish | * Shellfish |  | * Chicken | * Beef |
| * Whole Corn | * Soy, all ingredients |  | * Egg Substitute |  |
| Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Texture Modification** **PISD Nutrition Services is following the IDDSI Guidelines for food texture modifications. For more information on guidelines, please visits IDDSI.org**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Food Texture (select 1):** | | **Liquid texture (select 1):** | **Guidelines:** | **Duration:** |
|  | * Regular/Easy to Chew * Soft & Bite Sized (IDDSI level 6) * Minced & Moist (IDDSI Level 5) * Pureed (IDDSI Level 4) | * Thin/ Regular * Slightly Thick (IDDSI level 1) * Mildly Thick (Nectar, IDDSI level 2) * Moderately Thick (Honey, IDDSI Level 3) | * Pediatric * Adult | * Year-Round * Temporary:   Start:\_\_\_\_\_\_  Stop:\_\_\_\_\_\_\_ |

**Formula:** Is the student NPO or is this a supplement to accompany an oral diet? NPO Supplement

|  |
| --- |
| **Select one formula:**  Pediasure 1.0 Enteral Pediasure 1.0 w/Fiber Enteral Pediasure 1.0 Peptide Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dosage Per Meal: Breakfast:\_\_\_\_\_\_\_\_\_\_\_\_ Lunch:\_\_\_\_\_\_\_\_\_\_\_ After School (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**State Licensed Healthcare Professional Information**

Name of Licensed Healthcare Professional (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Licensed Medical Professional:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Clinic/Hospital:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Questions? Contact Nutrition Services at 713-740-0091  
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