**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
 In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint\_filing\_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

**4-e**