Willis ISD

Diet Modification Form

In accordance with U.S. Department of Agriculture regulations, WISD will provide meal substitutions when medically necessary for a student to access the District's meal program.

If your child has a medical condition that requires meal substitutions, complete and return this form to the nurse at your child's school.
Please allow up to two weeks for processing. If unable to accommodate, parent will be notified within that time-frame.

Student Name _____ Date of Birth _____

Campus Name _____ Student ID# _____ Grade _____ Teacher _____

By signing below, I acknowledge that it is my responsibility to notify any changes in my child's dietary needs in writing on this form. I give Child Nutrition Department 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 _____ E-Mail _____

Medical Information To be Completed By A State Licensed Healthcare Professional

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

Does the child have a **disability affecting major life activity requiring dies modification**? ___ No ___ Yes

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All".

- Cut up or chopped into bite size pieces: _____
- Finely ground: _____
- Pureed or Blended: _____

1. **Life threatening food allergy or food intolerance – Omit these foods:**
___ All dairy ___ fluid milk ___ cheese ___ peanuts ___ tree nuts ___ eggs ___ fish ___ shellfish
___ wheat ___ soy ___ gluten ___ corn

2. Can the student consume foods where **the allergen is an ingredient in the food product**? ___ No ___ Yes
(Example: scrambled eggs are not allowed but egg as an ingredient in pancakes is allowed)
Explain: _____
_____

3. Does your child's food allergy require an **epipen**? ___ No ___ Yes

State Licensed Healthcare Professional Information

Name of Licensed Healthcare Professional (Print) _____ Phone _____

Signature of Licensed Healthcare Professional _____ Date _____

Name of Clinic/Hospital _____