Willis Independent School District

612 N. Campbell Street, Willis, TX 77378
Child Nutrition Phone - 936.890.7730
Nurse Phone - 936.890.7484

WILLIS INDEPENDENT SCHOOL DISTRCIT - DIET MODIFICATION FORM

Please return the completed form to your student's campus nurse in person or email it to your designated campus nurse. Their email address can be found on the campus website.

Please allow up to 10 business days (two calendar 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 the nurse and the Child Nutrition Department of any changes in my student'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 a diet 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 ___ legumes

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 _____

Questions? Contact your campus nurse or the Child Nutrition Department at 936-890-7730