

Spring Independent School District – Child Nutrition

15330 Kuykendahl • Houston, Texas 77090 • Tel. 281-891-6445



PLEASE RETURN FORM TO THE SCHOOL NURSE

New Order
 Change Order
 Discontinue Order
 No Changes

Student Diet Modification Form (for cafeteria meals ONLY)

Revised 07/22

Student Last Name: _____ First Name: _____ MI: _____ Date of Birth: ____/____/____

Student ID#: _____ School: _____

Parent/Guardian Contact Information

Name (print): _____ Phone Number: _____ Email: _____

I give Child Nutrition & Health Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to Spring ISD.

Parent/Guardian Signature: _____ Date: _____

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

Breakfast
 Lunch
 Supper
 None (if student does not eat from the cafeteria, modifications will not be arranged)

Student has a **life-threatening/anaphylactic food allergy?**
 Yes (complete section A)
 No (complete section B)

If the student does NOT have a disability and/or food allergy, this form does not need to be completed and will be disregarded.

The following must be completed by a licensed physician or prescribing medical authority:

Section A: Food Allergy (check all foods to be omitted from diet):	Section B: Disability
<div style="display: flex; flex-wrap: wrap;"> <div style="margin-right: 10px;"><input type="checkbox"/> Peanuts</div> <div style="margin-right: 10px;"><input type="checkbox"/> Tree Nuts</div> <div style="margin-right: 10px;"><input type="checkbox"/> Fish</div> <div style="margin-right: 10px;"><input type="checkbox"/> Shellfish</div> <div style="margin-right: 10px;"><input type="checkbox"/> Wheat</div> </div> <div style="margin-top: 5px;"><input type="checkbox"/> Sesame</div> <p>Dairy Allergy (specify): <input type="checkbox"/> Fluid Milk Only <input type="checkbox"/> All Dairy Including in Baked Goods</p> <p>Egg Allergy (specify): <input type="checkbox"/> Whole Plain Eggs (ex. Scrambled eggs) <input type="checkbox"/> No Eggs Including in Baked Goods</p> <p>Soy Allergy (specify): <input type="checkbox"/> No Soy as a main ingredient (ex. Edamame, soy sauce, soy milk) <input type="checkbox"/> No Soy as a minor ingredient (ex. Soy filler in meats, soybean oil)</p> <p>Corn Allergy (specify): <input type="checkbox"/> No Corn as a main ingredient (ex. corn kernels, corn on the cobb) <input type="checkbox"/> No Corn as a minor ingredient (ex. corn oil, corn syrup)</p> <p>Other (please be specific) _____ _____</p> <p>Safe Food Substitutes: _____</p>	<p>Disability: _____ _____</p> <p>Major life activity affected by the disability (check all that apply):</p> <div style="display: flex; flex-wrap: wrap;"> <div style="margin-right: 10px;"><input type="checkbox"/> Major Bodily Function</div> <div style="margin-right: 10px;"><input type="checkbox"/> Breathing</div> <div style="margin-right: 10px;"><input type="checkbox"/> Seeing</div> <div style="margin-right: 10px;"><input type="checkbox"/> Speaking</div> <div style="margin-right: 10px;"><input type="checkbox"/> Learning</div> <div style="margin-right: 10px;"><input type="checkbox"/> Eating</div> <div style="margin-right: 10px;"><input type="checkbox"/> Hearing</div> <div style="margin-right: 10px;"><input type="checkbox"/> Walking</div> <div style="margin-right: 10px;"><input type="checkbox"/> Caring for One's Self</div> <div style="margin-right: 10px;"><input type="checkbox"/> Performing Manual Tasks</div> <div style="margin-right: 10px;"><input type="checkbox"/> Other: _____</div> </div> <p>Texture modification needed?:</p> <div style="display: flex; flex-wrap: wrap;"> <div style="margin-right: 10px;"><input type="checkbox"/> Regular</div> <div style="margin-right: 10px;"><input type="checkbox"/> Soft (ground)</div> <div style="margin-right: 10px;"><input type="checkbox"/> Pureed</div> <div style="margin-right: 10px;"><input type="checkbox"/> Soft (chopped)</div> </div> <p>Other: _____ _____ _____</p>

If student must omit MILK or EGGS AS AN INGREDIENT, SOY AS A MINOR INGREDIENT, WHEAT, or HAS MULTIPLE FOOD ALLERGIES, we must provide them with an Allergen Free Meal with very limited options

Name of Licensed Physician (print): _____ Physician's Signature: _____

Clinic Name & Address: _____ Date: _____ Phone: _____

Please allow up to 2 weeks for processing.

Questions? Contact Child Nutrition Services at 281-891-6445

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