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.

_____ Date: _____
Parent/Guardian Signature

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):

☐ **Peanuts** ☐ **Tree Nuts** ☐ **Fish** ☐ **Shellfish** ☐ **Wheat**
☐ **Sesame**

Dairy Allergy (specify): ☐ Fluid Milk Only
☐ All Dairy Including in Baked Goods

Egg Allergy (specify): ☐ Whole Plain Eggs (ex. Scrambled eggs)
☐ No Eggs Including in Baked Goods

Soy Allergy (specify):
☐ No Soy as a main ingredient (ex. Edamame, soy sauce, soy milk)
☐ No Soy as a minor ingredient (ex. Soy filler in meats, soybean oil)

Corn Allergy (specify):
☐ No Corn as a main ingredient (ex. corn kernels, corn on the cobb)
☐ No Corn as a minor ingredient (ex. corn oil, corn syrup)

Other (please be specific)_____
_____
Safe Food Substitutes:_____

Section B: Disability

Disability:
_____
_____

Major life activity affected by the disability (check all that apply):
☐ Major Bodily Function ☐ Breathing
☐ Seeing ☐ Speaking ☐ Learning
☐ Eating ☐ Hearing ☐ Walking
☐ Caring for One's Self
☐ Performing Manual Tasks
☐ Other:_____

Texture modification needed?:
☐ Regular ☐ Soft (ground)
☐ Pureed ☐ Soft (chopped)

Other: _____
_____
_____

******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