

Food Allergy Form

Physician's Diet Modifications (Section B & C to be completed by Physician)

A. THIS SECTION TO BE COMPLETED BY PARENT/LEGAL GUARDIAN
IF YOUR CHILD DOES NOT HAVE A LIFE THREATENING ALLERGY OR DISABILITY REQUIRING DIET MODIFICATION, DISREGARD THIS FORM

The U.S. Department of Agriculture School Meals Program requires that **ALL QUESTIONS BE ANSWERED** in order for **ANY** diet modification or substitution to be made in school meals.

Student Name _____ Date of Birth: _____ Campus: _____

Parent/Guardian Name _____ Phone: _____ Email: _____

1. Does your child have a **life threatening** food allergy? YES NO (If "yes", physician must complete section B and Parent must notify school nurse IMMEDIATELY.)
2. Does your child have a disability requiring diet modification? YES NO (If "yes", physician must complete section C.)

As parent/guardian, I give permission for Brazosport ISD to contact the Physician's office regarding my child's dietary needs.

Signature: _____ Date: _____

B. PHYSICIAN'S STATEMENT FOR STUDENT WITH LIFE THREATENING FOOD ALLERGY

1. Check all **LIFE THREATENING** food allergies – Omit these foods: Fluid Milk Peanuts Tree Nuts Eggs
 Fish Shellfish Wheat Soy Other (please specify): _____

2. Can the student consume foods where the allergen is **an ingredient in the food product**? YES NO
 (Example: scrambled eggs are omitted but egg as an ingredient in pancake is allowed)

Explain: _____

3. **Food to substitute:** *(Note BISD cannot honor this document unless substitutions are listed below)* _____

C. PHYSICIAN'S STATEMENT FOR STUDENT WITH DISABILITIES

1. List any disability requiring meal modification: _____
2. Explanation of why this disability restricts diet: _____
3. Major life activity affected by the DISABILITY (check all that apply):
 Eating Caring for ones' self Performing manual tasks Walking Seeing Hearing Speaking
 Breathing Learning
4. Foods to Omit: _____
5. **Food to substitute:** *(BISD cannot honor this document unless substitutions are listed below)* _____

 Physician's Signature

 Date

 Clinic/Facility Name & Address

 Telephone

**RETURN COMPLETED FORM TO CHILD NUTRITION OFFICE OR
 FAX COMPLETED FORM TO: 979-266-2420 ATTENTION: DIETITIAN**

The U.S. Department of Agriculture prohibits the discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.