



Splendor Independent School District

23419 FM 2090, Splendor, Texas 77372
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PADRE / TUTOR: **FORMULARIO DE DEVOLUCIÓN A LA ENFERMERA DE LA ESCUELA**

Nombre de padre/guardian _____

Nombre de estudiante _____

Nombre de campus _____ grado _____

Physician's Diet Modifications

Please complete this page for DISABILITIES/IMPAIRMENTS REQUIRING PHYSICIAN'S DIET MODIFICATION. The U.S. Department of Agriculture School Meals Program requires that all questions be answered in order for dietary substitutions and/or modifications to be made.

PHYSICIAN'S STATEMENT

I _____, Physician's Name (please PRINT)

Physician for _____ Child's Name (please PRINT)

declare the herein mentioned child to possess the following severe/life-threatening food allergies and/or special dietary needs related to a disability.

Disability/Impairment requiring meal modification: _____

If food allergy, is it LIFE-THREATENING? _____yes _____no

Reason for diet restriction: _____

Foods to Omit: _____

Foods to Substitute: _____

Physician Signature: _____ Date: _____

Physician Name: _____

Physician Address: _____

Physician Phone Number: _____