Splendora Independent School District

23419 FM 2090, Splendora, Texas 77372
281-689-3128 • Fax 281-689-7509

PARENT/GUARDIAN: **RETURN FORM TO SCHOOL NURSE**

Parent/Guardian Name:____

Student Name:____

Campus Name:____Student Grade:_________________

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:____

Right People • Right Things • Right Way • Right Resources • Right Relationships