



# Splendor Independent School District

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

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: \_\_\_\_\_