School Year _____

Exhibit B
Revised
11/19

Hondo Independent School District

Food Allergy/Disability Food Substitution Request Form

SECTION A: To be completed by Parent/Guardian. Form must be completed in its entirety in order for any diet modifications to be made. Incomplete forms will be returned. **PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE.**

Student's Name (Last, First):_____ **Date of Birth:**_____

School: _____ Student ID#: _____ Grade/Teacher: _____

Which meals will the student eat from the school cafeteria? (Check all that apply)

☐ Breakfast ☐ Lunch ☐ Snack* ☐ None (*if student does not eat from the cafeteria, modifications will not be arranged)*

**Snack only applies to after school tutoring programs*

Does the child have a **life-threatening food allergy?** **(Check box)** ☐ **No** ☐ **Yes (If yes, Physician completes section B)**

Has the child been prescribed an **EpiPen**? (Check box) ☐ **No** ☐ **Yes (If yes, please provide one to school nurse)**

Does the child have a **Disability requiring diet modification?** **(Check box)** ☐ **No** ☐ **Yes (If yes, Physician completes section C)**

I understand that if my child's medical or health needs change, it is my responsibility to notify the school nurse/office. I give Child Nutrition Service and/or School Nurse permission to speak with the Physician listed below to discuss the dietary needs described on this form. Also, I understand that this request must be renewed each school year and any further modifications will require a new form.

Printed Name _____

Parent/Guardian Signature _____ Date: _____

Phone Number: _____ Email: _____

******Sections B and C: To Be Completed By A Licensed Physician or Recognized Medical Authority******

Section B: Life-Threatening Food Allergy

☐All Dairy Products

Life-Threatening Food Allergy - Check all foods to be omitted from diet:

☐ Eggs ☐Fish ☐Peanuts ☐ Milk ☐ Shellfish ☐ Soy ☐ Tree nuts ☐ Wheat ☐ Corn ☐ Other

Specify: _____

Can the student consume foods where the allergen is an ingredient in a product? ☐ Yes ☐ No

(I.e. Can consume eggs in baked goods, but not scrambled eggs.) (I.e. Can consume soy oil but not whole soy beans or TVP)

Explain: _____

_____

Safe Food Substitutes: _____

Section C: Disability

Disability: _____

Major life activity affected by the disability (check all that apply):

☐Breathing ☐Seeing ☐Speaking ☐Performing manual tasks ☐ Learning

☐Eating ☐Hearing ☐Walking ☐Caring for one's self ☐ other: _____

Type of Diet: ☐ Regular ☐ Soft Mechanical ☐Chopped ☐ Blended ☐ Pureed ☐ Liquid: Clear ☐Thickened

Foods to be omitted: _____

Safe Food Substitutes: _____

Licensed Physician Name (print):_____ Physician Signature:_____Date:__/__/__

Address:_____ Phone:_____ Fax:_____

Received by HISD Nurse on _____/_____/_____ Campus Nurse Name:_____

*Copy to Cafeteria Manager: Date Sent___/___/___ Copy to Nutrition Services: Date Sent___/___/_____CN>*NK __/__/__