



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** ___/___/___

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