STUDENT NAME (LAST, FIRST): _____ **DATE OF BIRTH:** _____

Red Oak Independent School District

2024-2025 DIET MODIFICATION REQUEST FORM

For Students with Disabilities and/or Life-Threatening (Anaphylaxis) Food Allergies

****Please return form to school nurse upon completion****

The Student Nutrition Department is required by the United States Department of Agriculture (USDA) to provide appropriate menu substitutions to students with life-threatening allergies (those that can cause anaphylactic reactions), or for students with disabilities that restrict their diet.

If you have questions, please contact the Student Nutrition Department's Director, Victoria Ybarra, victoria.ybarra@redoakisd.org; (972) 617-2941.

PLEASE NOTE: The only milk substitutes the Student Nutrition Department provides to non-disabled students who cannot drink fluid milk due to a medical or special dietary need is lactose-free cow's milk (such as Lactaid) or soy milk. All other alternative fluid milks require a completed Diet Modification Request Form. Milk is not required to be taken as part of Offer-vs-Serve regulations, and water is available as a beverage for all students.

THIS FORM MUST BE COMPLETED BY A LICENSED PHYSICIAN

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modifications or substitutions to be made to school meals.

A) Does the Child have a Disability or a life-threatening allergy?* ☐ **Yes** ☐ **No**

Under Section 504 of the Rebabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment or is regarded as having such an impairment

B) The student listed above possesses the following disability or life-threatening allergy: _____

C) Explanation of why this disability restricts diet:

_____

_____

D) Major Life Activities affected by the disability/life-threatening allergy *(check all that apply):*

☐ Caring for one's self ☐ Eating ☐ Walking ☐ Seeing ☐ Hearing
☐ Learning ☐ Speaking ☐ Breathing ☐ Performing Manual Tasks

FOOD/BEVERAGE SUBSTITUTIONS (MUST BE FILLED OUT BY A LICENSED PHYSICIAN):

A) Foods/Beverages to omit: _____

B) Foods/Beverages to Substitute with: _____

C) Can the student consume foods where the allergen(s) is an ingredient in the food product (for example, eggs are omitted, but eggs as an ingredient in waffles is allowed?): _____

D) Texture Modification, if applicable:

LIQUIDS ☐ Thin
Thickened: ☐ Nectar ☐ Honey ☐ Pudding

SOLIDS ☐ Mechanical Soft Chopped ☐ Pureed
☐ Mechanical Soft Ground

Please provide additional comments or information as related to diet and/or feeding techniques (attach additional pages, if needed):

_____

_____

PHYSICAN SIGNATURE

I certify that the above named student needs to be offered food substitutions as described above because of the student's disability/life-threatening food allergy as indicated.

Printed Physician's name | **Physician's Signature** | **Date**

Clinic/Facility | **Phone Number** | **Fax Number**

PARENT/GUARDIAN SIGNATURE

I understand that this form will remain on file each year. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the Student Nutrition Department and to the School Nurse.

Parent/Guardian Signature | **Date** | **Phone** | **Email Address**

SCHOOL NURSE/OFFICE PERSONNEL USE ONLY

Student ID# _____ **Student Name:** _____ **School:** _____

School RN Name: _____