

**WEIMAR ISD PHYSICIAN DIET MODIFICATION**

**SECTION A – To be completed by Parent/Legal Guardian Student’s**

**Name (Last, First)** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
**School** \_\_\_\_\_ **Grade** \_\_\_\_\_  
**Parent/Guardian** \_\_\_\_\_ **Home Phone** \_\_\_\_\_  
**Parent/Guardian Email** \_\_\_\_\_

I give Nutrition Services/Health Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below. 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 Nutrition and Food Service dietician and the school nurse.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Student has life threatening/anaphylactic food Allergies?**  Yes (complete Section B)  No (complete Section C)

**SECTION B: FOOD ALLERGIES - TO BE COMPLETED BY A LICENSED PHYSICIAN OR PRESCRIBING MEDICAL AUTHORITY**

Peanuts \_\_\_\_\_ Tree Nuts \_\_\_\_\_  
 Seeds (specify): Sesame \_\_\_\_\_ Sunflower \_\_\_\_\_  
 Other Seeds (describe) \_\_\_\_\_  
 Dairy Allergy (specify): Fluid Milk Only \_\_\_\_\_ Cheese \_\_\_\_\_  
 Yogurt \_\_\_\_\_ All Dairy including in baked goods \_\_\_\_\_  
 Egg Allergy (specify): Whole Plain Eggs (ex. Scrambled eggs) \_\_\_\_\_  
 No Eggs in baked goods \_\_\_\_\_  
 No Fish \_\_\_\_\_ No Shellfish \_\_\_\_\_ No Wheat \_\_\_\_\_  
 No Soy as a main ingredient (ex. Edamame, soy sauce, soy milk) \_\_\_\_\_  
 No Soy as a minor ingredient (ex. Soy in processed foods, soy oil, soy lecithin) \_\_\_\_\_  
 No Corn as a main ingredient (ex. Corn kernels, corn tortillas) \_\_\_\_\_  
 No Corn as a minor ingredient (ex. Cornstarch, cornmeal, corn syrup, corn oil, corn flour) \_\_\_\_\_  
 Other (please be specific): \_\_\_\_\_

**Substitutions:** (Weimar ISD cannot honor this document unless substitutions are listed below)

**SECTION C: DISABILITY - TO BE COMPLETED BY A LICENSED PHYSICIAN OR PRESCRIBING MEDICAL AUTHORITY**

**Disability:** \_\_\_\_\_

**Major Life Activity affected by the Disability (REQUIRED)**

- Major Bodily Function  Eating  Breathing
- Performing manual tasks  Caring for one's self
- Speaking  Learning  Walking  Hearing  Seeing
- Other: \_\_\_\_\_

**Foods to Omit:** \_\_\_\_\_

**Substitutions:** (Weimar ISD cannot honor this document unless substitutions are listed below)

**Texture Modification Needed?** Yes No

**Liquids:** Thin Nectar Thick Honey Thick Pudding Thick  
**Solids:** Pureed Mechanical Soft (chopped)  
 Mechanical Soft (ground)

**Supplement Needed?** Yes No

**Supplement:** \_\_\_\_\_  
**Alternative Supplement:** \_\_\_\_\_  
**Dosage Per Meal:** Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_  
 \*Weimar ISD Food Service will attempt to honor requests for supplements based on product availability.

**Therapeutic Diet Order: (please provide specifics below)**

*I certify that the above named student needs to be offered food substitution as described above because of the student's disability and/or life threatening food allergy.*

**Printed Name of Licensed Physician/Prescribing Medical Authority:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Physician/Prescribing Medical Authority:** \_\_\_\_\_  MD  DO  PA  NP  SLP

**Clinic/Facility Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

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