

**Henrietta ISD Health Services  
Physician Authorization for Diet Modifications**

Campus:

20\_\_-20\_\_

**The U.S. Department of Agriculture School Meals Program requires that your child's physician answer all questions in order for any diet modifications to be made in school meals.**

<b>STUDENT</b>	<b>DOB</b>	<b>CAMPUS/GRADE/HR</b>
<b>List any disability/diagnosis requiring meal modification</b>		
<b>Life-threatening food allergy if applicable: (check foods to omit)</b>	<input type="checkbox"/> fluid milk <input type="checkbox"/> peanuts <input type="checkbox"/> tree nuts <input type="checkbox"/> eggs <input type="checkbox"/> fish <input type="checkbox"/> shellfish <input type="checkbox"/> wheat <input type="checkbox"/> soy <input type="checkbox"/> other, specify: _____	
<b>Can the student consume foods where the allergen is an ingredient in the food product/recipe?</b>	<input type="checkbox"/> yes <input type="checkbox"/> no Explain: _____	
<b>Foods not allowed(specify):</b>		
<b>Major life activity affected by the disability, if applicable</b>	<input type="checkbox"/> learning <input type="checkbox"/> performing manual tasks <input type="checkbox"/> speaking <input type="checkbox"/> breathing <input type="checkbox"/> hearing <input type="checkbox"/> seeing <input type="checkbox"/> other, specify: _____	
<b>Other instructions:</b>		

Physician (print name)	Phone
Physician Signature	Date

<p><b>Please return completed form to the campus nurse or fax to : Brittanie Brown HISD Food Services Director 940.538.7515</b></p>
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