College Station Independent School District – Child Nutrition
1812 Welsh Ave • College Station, Texas 77840 • Tel. 979-764-5450 • Fax 979-764-5585

PLEASE RETURN FORM TO THE CHILD NUTRITION OFFICE

Student Diet Modification Form (for cafeteria meals ONLY)

Revised 6/19

Student Last Name:_____ First Name:_____

Date of Birth:_____/_____/_____ School:_____

Parent/Guardian Contact Information

Name (print):_____Phone Number: _____Email: _____

I give Child Nutrition & 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 College Station ISD.

_____ Date: _____
Parent/Guardian Signature

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

☐ Breakfast ☐ Lunch ☐ None

(Modifications will only be made if a meal session box is selected. Only full meals are modified. A la carte and snack purchases should be monitored by student and guardians).

Student has a **life-threatening/anaphylactic food allergy?** ☐ **Yes (complete section A)** ☐ **No (complete section B)**

If the student does NOT have a disability and/or food allergy, this form does not need to be completed and will be disregarded.

The following must be completed by a licensed physician or prescribing medical authority:

Section A: Food Allergy (check all foods to be omitted from diet):

☐**Peanuts** ☐**Tree Nuts** ☐**Fish** ☐**Shellfish** ☐**Wheat**

Dairy Allergy (specify): ☐ Fluid Milk Only
☐ All Dairy Including in Baked Goods

Egg Allergy (specify): ☐Whole Plain Eggs (ex. Scrambled eggs)
☐ No Eggs Including in Baked Goods

Soy Allergy (specify):
☐No Soy as a main ingredient (ex. Edamame, soy sauce, soy milk)
☐No Soy as a minor ingredient (ex. Soy filler in meats, soybean oil)

Corn Allergy (specify):
☐No Corn as a main ingredient (ex. corn kernels, corn on the cobb)
☐No Corn as a minor ingredient (ex. corn oil, corn syrup)

Other (please be specific)_____
_____
Safe Food Substitutes:_____

Section B: Disability

Disability:
_____

Major life activity affected by the disability (check all that apply):
☐ Breathing ☐ Seeing ☐ Speaking
☐ Learning ☐ Eating ☐ Hearing
☐ Walking ☐ Caring for One's Self
☐ Performing Manual Tasks
☐ Other:_____

Texture modification needed?:
Solids: ☐ No Solids ☐ Pureed ☐ Chopped
☐ Mechanical Soft ☐ Regular

Liquids: ☐ No Liquids ☐ Thin ☐ Thickened
☐ Nectar ☐ Honey ☐ Pudding
Other: _____

Name of Licensed Physician (print): _____Physician's Signature: _____
Clinic Name & Address: _____Date:_____Phone:_____

Please allow up to 2 weeks for processing. Questions? Contact Child Nutrition Services at 979-764-5450