

MEDICAL STATEMENT for CHILD NUTRITION DEPARTMENT (SCHOOL CAFETERIA) (PAGE 1 OF 2)

COMPLETE ONLY IF YOUR CHILD NEEDS DIET MODIFICATION IN CAFETERIA

FAX COMPLETED MEDICAL STATEMENT TO: 281-641-1072 ATTENTION: DIETITIAN

Note: This form does NOT need to be filled out every year. Fill out new form only if food allergies have changed since last year. The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Parent/Guardian Name _____
Campus Name _____

Student Name _____
Date of Birth _____

PART A – If your child has a food allergy or special diet but will NOT eat food from the Humble ISD cafeteria, please sign below. There is NO NEED TO COMPLETE the rest of this form if your child will not eat in the cafeteria. If you sign this section, a block will be placed on your child’s account preventing all purchases from the cafeteria.

Parent/Guardian Signature

Telephone

PART B – STUDENTS WITH LIFE THREATENING FOOD ALLERGIES ONLY MUST HAVE THIS SECTION COMPLETED BY A MEDICAL AUTHORITY THAT IS LICENSED BY THE STATE TO WRITE MEDICAL PRESCRIPTIONS.

(If there is NO LIFE THREATENING FOOD ALLERGY, SKIP THIS SECTION, and GO TO PART C on back of page.)

Date _____

I, _____, declare the child listed above to possess a LIFE THREATENING FOOD ALLERGY
Medical Authority (Physician) Name (please PRINT)

1. Life threatening food allergy (Circle all foods that must be omitted from diet):

fluid cow’s milk peanuts tree nuts eggs fish shellfish wheat soy
other life threatening food allergy, please specify: _____

2. Can the student consume foods where the allergen is an ingredient in the food product? yes no
(Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)

Explain _____

3. Explanation of why this allergy restricts diet (NOTE: Humble ISD cannot honor this document unless an explanation is provided.)

4. Major life activity affected by the medical condition (check all that apply): (NOTE: Humble ISD cannot honor this document unless at least one life activity is marked.)

bending concentrating lifting seeing thinking
breathing eating major bodily function sleeping walking
caring for oneself hearing performing manual tasks speaking working
communicating learning reading standing
other not listed, please specify: _____

5. Foods to Substitute (NOTE: Humble ISD cannot honor this document unless SPECIFIC SUBSTITUTIONS are listed below or medical authority (physician) refers patient to registered dietitian who specifies menu items.)

Medical Authority (Physician) Signature

Date

Telephone

Clinic/Facility Name & Address

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MEDICAL STATEMENT for CHILD NUTRITION DEPARTMENT (SCHOOL CAFETERIA) (PAGE 2 OF 2)

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Parent/Guardian Name _____
Campus Name _____

Student Name _____
Date of Birth _____

PART C – STUDENTS WITH A MEDICAL CONDITION THAT AFFECTS THEIR PARTICIPATION IN THE SCHOOL MEAL PROGRAM MUST HAVE THIS SECTION COMPLETED BY A MEDICAL AUTHORITY THAT IS LICENSED BY THE STATE TO WRITE MEDICAL PRESCRIPTIONS

Date _____

I, _____, declare the child listed above to possess a MEDICAL CONDITION that restricts the child’s diet.
Medical Authority (Physician) Name (please PRINT)

1. Circle any option below that requires diet modification:

- | | | | | |
|--------------------|------------------------|---|--------------------|---------------------------|
| autism | muscular dystrophy | heart disease | hemophilia | asthma |
| cerebral palsy | multiple sclerosis | HIV | rheumatic fever | sickle cell anemia |
| epilepsy | cancer/leukemia | tuberculosis | nephritis | lead poisoning |
| speech impairment | traumatic brain injury | emotional disturbance | metabolic disorder | drug addiction/alcoholism |
| visual impairment | orthopedic impairment | | | |
| hearing impairment | mental retardation | other not listed, please specify: _____ | | |

2. In order to make a diet modification, an explanation of how the medical condition restricts the diet is required. (NOTE: Humble ISD cannot honor this document unless an explanation is provided.) _____

3. Major life activity affected by the medical condition (check all that apply): (NOTE: Humble ISD cannot honor this document unless at least one life activity is marked.)

- | | | | | |
|---|-------------------|-----------------------------|--------------|--------------|
| ___ bending | ___ concentrating | ___ lifting | ___ seeing | ___ thinking |
| ___ breathing | ___ eating | ___ major bodily function | ___ sleeping | ___ walking |
| ___ caring for oneself | ___ hearing | ___ performing manual tasks | ___ speaking | ___ working |
| ___ communicating | ___ learning | ___ reading | ___ standing | |
| ___ other not listed, please specify: _____ | | | | |

4. Foods to Omit (NOTE: Humble ISD cannot honor this document unless SPECIFIC FOODS TO OMIT are listed below or medical authority (physician) refers patient to registered dietitian who specifies menu items.)

5. Foods to Substitute (NOTE: Humble ISD cannot honor this document unless SPECIFIC SUBSTITUTIONS are listed below or medical authority (physician) refers patient to registered dietitian who specifies menu items.)

Medical Authority (Physician) Signature

Date

Telephone

Clinic/Facility Name & Address

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