Humble ISD Child Nutrition Ashley Phelps, MCN, RD, LD, SNS Dietitian (281) 641-8735 (phone) ashley.phelps@humbleisd.net

# 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_____ Student Name_____
Campus 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





For Office Use Only: ☐ approved ☐ denied _____ date POS note entered _____ initials

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# MEDICAL STATEMENT for CHILD NUTRITION DEPARTMENT (SCHOOL CAFETERIA) (PAGE 2 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_____ Student Name_____
Campus 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





For Office Use Only: ☐ approved ☐ denied _____ date POS note entered _____ initials