Humble ISD Child Nutrition Kara Lam, RDN, LD Assistant Director (281) 641-8462 (phone) kara.lam@humble.k12.tx.us

FAX TO: 281-641-1072 ATTENTION: DIETITIAN

CAFETERIA – COMPLETE ONLY IF YOUR CHILD NEEDS DIET MODIFICATION IN CAFETERIA

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 _____

As parent or guardian, I give **permission for Humble ISD to contact the Physician's office regarding my child's dietary needs.**

_____(Parent/Guardian Signature)

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.

_____ _____

Parent/Guardian Signature Telephone

PART B – STUDENTS WITH LIFE THREATENING FOOD ALLERGIES ONLY MUST HAVE THIS SECTION COMPLETED BY A PHYSICIAN.

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

PHYSICIAN'S STATEMENT Date _____

I declare the child listed above to possess a LIFE THREATENING FOOD ALLERGY. _____

Physician's Name (please PRINT)

1. Life threatening food allergy – Circle all foods that must be omitted:

fluid cow's milk peanuts tree nuts eggs fish shellfish wheat soy

other life threatening food allergy, 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 disability restricts diet: _____

4. Major life activity affected by the life threatening food allergy (check all that apply):

(*NOTE: Humble ISD cannot honor this document unless at least one life activity is marked.)*

____ eating ____caring for one's self ____performing manual tasks ____walking
____ hearing ____ speaking ____breathing ____learning ____seeing

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

_____

_____

_____ _____

Physician's Signature Date

_____ _____

Telephone Clinic/Facility Name & Address

Humble ISD Child Nutrition Kara Lam, RDN, LD Assistant Director (281) 641-8462 (phone) kara.lam@humble.k12.tx.us

CAFETERIA – COMPLETE ONLY IF YOUR CHILD NEEDS DIET MODIFICATION IN CAFETERIA

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 _____

As parent or guardian, I give **permission for Humble ISD to contact the Physician's office** regarding my child's dietary needs.

_____(Parent/Guardian Signature)

PART C – STUDENTS WITH DISABILITIES MUST HAVE THIS SECTION COMPLETED BY A PHYSICIAN.

PHYSICIAN'S STATEMENT Date _____

I declare the child listed above to possess a DISABILITY. _____
Physician's Name (please PRINT)

1. Circle all disabilities requiring meal 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**		
visual impairment	**orthopedic impairment**	**drug addiction/alcoholism**		
hearing impairment	**mental retardation**	**metabolic disorder, specify _____**		

2. In order to make a diet change, an explanation of how the disability restricts diet is required.

_____

3. Major life activity affected by the DISABILITY (check all that apply):

(*NOTE: Humble ISD cannot honor this document unless at least one life activity is marked.)*

____ eating ____caring for one's self ____performing manual tasks ____walking ____seeing
____ hearing ____ speaking ____breathing ____learning ____ other, specify_____

4. Foods to Omit:

_____
_____
_____

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

_____
_____
_____
_____

_____ _____
Physician's Signature Date

_____ _____
Telephone Clinic/Facility Name & Address