



PHYSICIAN'S DIET MODIFICATION

Student Name _____ Student ID # _____ DOB _____
 Campus _____ Parent/Guardian _____ Telephone _____

As parent or guardian, I give permission for C-FB ISD to contact the Physician's office regarding my child's dietary needs. _____ (Parent Signature)

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.

This form must be signed by a licensed physician.

Physician's Statement

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

either a **LIFE THREATENING FOOD ALLERGY** or a **DISABILITY**:

LIFE THREATENING FOOD ALLERGY – Omit these foods (circle):

fluid milk peanuts tree nuts eggs fish shellfish wheat soy other _____

OR

DISABLING DIAGNOSIS REQUIRING DIETARY MODIFICATION:

1. Can the student consume foods where the allergen is an ingredient in the food product? ___ yes ___ no
 (Example: Any foods that contain eggs or milk are unacceptable.)

Explain _____

2. Explanation of why this disability restricts diet:

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

(NOTE: C-FB 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

4. Foods to Substitute (NOTE: C-FB ISD cannot honor this document unless substitutions are listed below.)

Physician's Signature _____ **Date** _____

Telephone _____ **Clinic/Facility** _____

For questions, contact Personnel Coordinator-Student Nutrition: Genny D'Souza at 972-968-6388. (Fax 6392)

Non-Discrimination Statement: This explains what to do if you believe you have been treated unfairly: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.