Belton ISD Nutrition Program
FOOD ALLERGY/DISABILITY SUBSTITUTION REQUEST

Date _____ Student's Date of Birth _____ Student ID# _____

Student info (printed)
Last Name _____ First Name _____

Parent or Guardian Name (printed) _____

Daytime Phone _____ Email _____

Mailing address _____ City _____ Zip _____

I understand that it is my responsibility to review the school menus with my child to select allergy-appropriate menu items. If my child is unable to select allergy-appropriate menu items from the published menu, I must contact the Child Nutrition Department to request a menu accommodation.
I give Belton ISD Nutrition Program permission to speak with the below named physician or recognized medical authority to discuss the dietary needs described below.
I understand it is my responsibility to renew this form should my child's nutritional needs change. To remove allergy restrictions from this student's account, the parent/guardian must submit a signed note, from the students physician stating that the student no longer has the food allergy or intolerance.

Parent's Signature _____

THIS SECTION MUST BE COMPLETED BY THE STUDENT'S TREATING PHYSICIAN. PLEASE PRINT.

Does the child have an identified disability and/or life-threatening food allergy?

☐ **YES** Complete Part A – Disability or Severe Life Threatening Food Allergy ☐ **NO** Complete Part B – Food Intolerance/Allergy

☐ A. DISABILITY, INCLUDING ***SEVERE***, LIFE THREATENING FOOD ALLERGY

Student has a disability and requires a special diet or food accommodation. An individual with a disability is described under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990 as a person with any physiological disorder or conditions, cosmetic disfigurement, or anatomical loss affecting the body's systems or any mental or psychological disorder which affects one of the major life activities.

Explanation of the disability or medical condition requiring meal accommodations: _____

Student's food allergy/restrictions related to their disability:

Eggs: ☐ Whole Eggs ☐ Egg as an ingredient, i.e., scrambled eggs are omitted and egg as an ingredient in pancakes is not allowed

Nuts: ☐ Peanuts ☐ Tree Nuts

Dairy Allergy: ☐ No fluid milk ☐ Avoid all dairy products (cheese, yogurt, ice cream) ☐ Avoid milk in all baked goods

NOTE: Ice water and cups are located in the dining area, and are available to all students at no charge.

☐ Fish ☐ Shellfish ☐ Wheat ☐ Soy ☐ Other _____

☐ Diabetic *NOTE: Menu selections must be made on the school calendar menu per Doctor's orders/individual health plan.*

Major life activity affected by the disability (check all that apply) ☐ Eating ☐ Walking ☐ Seeing ☐ Major bodily functions
☐ Reading ☐ Hearing ☐ Speaking ☐ Breathing ☐ Learning ☐ Performing manual tasks ☐ Other

Foods to omit from diet: _____

Safe food substitutes* **(required)**: _____

☐ B. FOOD INTOLERANCE/ALLERGY NOT CONSIDERED A MEDICAL DISABILITY

Student does not have a disability but is requesting a special meal or dietary accommodation. Student's allergy/intolerance to food(s) below does not significantly affect one or more major life activities, as defined above. The Child Nutrition Department may make reasonable accommodations, as long as accommodation requests still meet meal pattern requirement.

Eggs: ☐ Whole Eggs ☐ Egg as an ingredient, i.e., scrambled eggs are omitted and egg as an ingredient in pancakes is not allowed

Nuts: ☐ Peanuts ☐ Tree Nuts

Lactose Intolerance/Dairy Allergy: ☐ No fluid milk* ☐ Avoid all dairy products (cheese, yogurt, ice cream) ☐ Avoid milk in all baked goods

NOTE: Water is available to all students at no charge. Ice water and cups are located in the dining area.

☐ Fish ☐ Shellfish ☐ Wheat ☐ Soy ☐ Other _____

Foods to omit from diet: _____

Safe food substitutes* **(required)**: _____

*The Child Nutrition Department will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability. Water is available to all students at no charge. Ice water and cups are located in the dining area.

I certify that the above named student needs to be offered food substitutes as described above because of the student's disability, food allergy, food intolerance, and/or other medical condition.

Name of Physician _____ Telephone Number _____

Address (Street, City, State, ZIP) _____

Signature _____ Date _____

PHYSICIAN'S SIGNATURE IS REQUIRED

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