**Belton ISD Health Services**
**Physician Authorization for Diet Modifications**
School Year: **Campus**:

**The U.S. Department of Agriculture School Meals Program requires that your child's physician answer all questions in order for any diet modifications to be made in school meals.**

**STUDENT ID:**

| **STUDENT:** | **DOB** | **CAMPUS/GRADE/HR** |
|---|---|---|
| | | |
| **PARENT OR GUARDIAN NAME:** | **PHONE:** | **EMAIL:** |
| | | |

| | |
|---|---|
| **Does the child have an identified disability and/or life-threatening food allergy?** | YES ☐ NO ☐ |
| **Check Life-threatening foods to omit.** | ☐fluid milk ☐peanuts ☐tree nuts ☐eggs ☐fish ☐shellfish ☐wheat<br>☐soy ☐other, specify:_____ |
| **Can the student consume foods where the allergen is an ingredient in the food product/recipe (cooked/baked)?** | YES ☐ NO ☐<br>Explain: |
| **Foods not allowed(specify):** | |
| **Allowable Food Substitutions:** | |
| **Major life activity affected by the disability, if applicable** | ☐learning ☐performing manual tasks ☐speaking ☐breathing ☐hearing<br>☐seeing ☐other, specify: _____ |
| **Other instructions:** | |

| Physician (print name) | Phone |
|---|---|
| | |
| Physician Signature | Date |
| | |

**I am giving permission for my child's medical provider to release this completed form back to his/her school nurse and for the BISD school nurse to contact my physician for additional information if necessary and to notify my child's teacher(s) of his/her health condition.**

| **Parent signature** | **Best emergency phone** | **Other phone** | **Date** |
|---|---|---|---|
| | | | |

**Please fax completed form to Belton ISD Health Services Department**

**254-215-2097 or email to health.services@bisd.net**