FLOUR BLUFF INDEPENDENT SCHOOL DISTRICT
Corpus Christi, Texas

OFFICE OF SCHOOL NUTRITION
Student Diet Modification Form

NOTICE TO PARENTS OF CHILDREN WITH DISABILITIES

The parent/legal guardian is responsible for providing the required documentation for special diet requests, the Student Diet Modification Form, found on the next page.

Please return the completed form to:

Flour Bluff ISD - Office of School Nutrition
Attn: Brittany Buchanan RDN, LD
2505 Waldron Road
Corpus Christi, Texas 78418
Phone: 361-694-9251
Fax: 361-694-9812
Email: bbuchanan@flourbluffschools.net

The school nurse and cafeteria manager will be notified after the form is processed.

To better serve our students, the parent/legal guardian is responsible for completing and submitting a new form whenever changes occur in the student's medical condition.

Manufacturers provide food labels to the FBISD Office of School Nutrition annually. Product reformulation may occur at any time and may not be known by our department. In addition, distributors may deliver (on short notice) alternate/substitute products which contain unexpected allergens. Because of this, the FBISD Office of School Nutrition cannot be responsible for ensuring that a child's menu selections are free from allergens.

Students with life-threatening food allergies are encouraged to bring meals from home.

Section A:
The intent of Section A is to provide basic information needed to submit the request into the system. A parent/guardian should complete this section.

Section B:
The intent of Section B is to provide alternatives for students with severe illnesses/conditions/allergies that are related to food consumption. This section should be completed in its **entirety** by the treating physician and **requires** a physician signature.

Section C:
This section must be completed in its entirety regarding the mechanical alteration of a regular diet. It should be completed to assist the student with consumption of the meal. This section **does not require** a physician's signature, but **does require** a requesting party signature.

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A. THIS SECTION TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Student Name: _____ Date of Birth: _____

Campus: _____ Student ID Number: _____

Guardian Name: _____ Phone: _____

Which meals will the student eat FROM THE SCHOOL CAFETERIA? (Check all that apply)

☐ Breakfast ☐ Lunch ☐ None (If student does not eat from the cafeteria, modifications will not be arranged)

As Parent or Guardian, I give **permission for Flour Bluff ISD** to contact the Physician's office regarding my child's dietary needs.

Signature: _____ Date: _____

B. PHYSICIAN'S STATEMENT FOR STUDENTS WITH LIFE THREATENING FOOD ALLERGY

1. Mark all **LIFE THREATENING** food allergies- Omit these foods: ☐ fluid milk ☐ peanuts ☐ tree nuts ☐ eggs ☐ fish ☐ shellfish
   ☐ Soy ☐ Wheat ☐ Other (please specify): _____
2. List any disability requiring meal modification: _____
3. Major life activity affected by disability (Check all that apply):
   ☐ Eating ☐ Caring for self ☐ Performing manual tasks ☐ Walking
   ☐ Seeing ☐ Hearing ☐ Speaking ☐ Breathing ☐ Learning
4. Can the student consume foods where the allergen is an ingredient in the product? ☐ Yes ☐ No
   (Example: can consume eggs in baked goods, but not scrambled eggs)
   Explain: _____
   _____
5. Safe Food Substitutes *(FBISD cannot honor this document unless substitutions are listed below)*:
   _____
   _____

Physician's Signature_____ **Date**_____

Clinic Name_____ **Telephone/Fax Number**_____

C. STATEMENT FOR STUDENTS NEEDING TEXTURE MODIFICATION

1. List any disability requiring texture modification: _____
2. Major life activity affected by disability (Check all that apply):
   ☐ Eating ☐ Caring for self ☐ Performing manual tasks ☐ Walking
   ☐ Seeing ☐ Hearing ☐ Speaking ☐ Breathing ☐ Learning
3. Type of mechanical alteration:
   ☐ Pureed ☐ Ground ☐ Chopped (chopped diets will be altered on site by aides)
4. Signature of requesting party: _____

D. For Office Use Only

Date Received: _____