



Food Allergy/ Special Dietary Needs Physician Order

Student's Name (Last, First)

Student ID Number

Date of Birth

Campus

To be completed by Physician/Medical Authority

I. Does the student have a disability? ____ Yes ____ No

If yes, check the major life activities affected by the disability and reason the disability prevents the child from eating the regular school meal.

____ breathing ____ eating ____ hearing ____ learning ____ seeing ____ speaking ____ walking ____ performing manual tasks ____ caring for one's self

Student has the following allergy:

____ Dairy Allergy: ____ No Fluid Dairy Milk ____ No Yogurt ____ No Cheese ____ Avoid all dairy products even in baked goods

____ Egg Allergy: ____ No Whole Eggs ____ No Egg Whites ____ No Eggs in baked goods

____ No Wheat ____ No Peanut ____ No Tree Nut ____ No Corn ____ No Fish ____ No Shellfish

____ Soy Protein Allergy (can tolerate soy oil and soy lecithin) ____ Soy Allergy including soy oil and soy lecithin

____ Other (Please list) :

II. Foods to Substitute or modify: (A list of substitutions is required):

III. Treatment Plan: Physician to check appropriate medication(s)

Food allergen ingested- no symptoms ____ Epinephrine ____ Antihistamine

Respiratory- wheezing, shortness of breath, coughing ____ Epinephrine ____ Antihistamine

Cardiovascular- low blood pressure, weak pulse, pale or blue ____ Epinephrine ____ Antihistamine

Gastrointestinal- nausea, vomiting, diarrhea, cramping ____ Epinephrine ____ Antihistamine

Skin- hives, itching, rash, swelling of face/extremities ____ Epinephrine ____ Antihistamine

Mouth- swelling lips/tongue, itching, tingling ____ Epinephrine ____ Antihistamine

Throat- tightening, hoarseness, coughing ____ Epinephrine ____ Antihistamine

Symptoms Worsening- ____ Epinephrine ____ Antihistamine

IV. Medications/Doses

Epinephrine (brand and dose): Antihistamine (brand and dose):

Is the student asthmatic? ____ Yes ____ No Bronchodilator (brand and dose):

Physician recommendation for medication self-administration:

(Initial one) ____ The student above has been instructed by me in the proper way to use his/her medication(s). It is my professional opinion that he/she be allowed to carry and self-administer the above medications while on school property or at school related events.

(Initial two) ____ The student above in my professional opinion should NOT be allowed to carry and self-administer any of the above medication(s) while on school property or at school related events.

V. Texture Modification

____ Year Round ____ Temporary: Start ____ Stop: ____

Liquids: ____ Thin (Regular liquids) ____ Nectar thick ____ Honey Thick

Solids: ____ Mechanical Soft (chopped) ____ Mechanical Soft (ground) ____ Pureed (Applesauce Texture)

VI. Therapeutic Diet Order: (If applicable)

To be completed only by STUDENT'S TREATING PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER

I certify that the above named student needs to be offered food substitutions as described above. A marked menu may be provided to allow for a set menu that meets student's special diet needs.

Printed Name of Medical Authority Signature of Medical Authority DATE

____ MD ____ DO ____ PA-C ____ NP

CONTACT TELEPHONE NUMBER

To be completed & signed by Parent/Guardian

I understand as a parent/guardian, that it is my responsibility to renew this form every 12 months or **any time there is a change or discontinuation of dietary needs** and give to the school nurse. I give NISD Child Nutrition Dept and/or School nurse permission to speak with the medical authority to discuss dietary/medication needs as ordered. **Completed forms may be returned to the cafe manager, school nurse or emailed to the Child Nutrition Dept at: Specialdiets@nisd.net. Please contact (210) 397-4504 with questions.**

X

Parent/Guardian Signature Date Printed Parent/Guardian Name Parent/Guardian Contact Number

Parent/Guardian Email Address (CLEARLY PRINT)