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

____ NoWheat _____ 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)