School Year ______--______

Pasadena Independent School District's Diet Modification Form

Revised 6/23

PLEASE RETURN FORM TO THE SCHOOL NURSE

Please allow up to 2 weeks for processing. If unable to accommodate, parent will be notified in that time frame.

Student Information

Student's Name* (Last, First):______________________________ DOB:________________ Student ID#: ______________

By signing below, I acknowledge that it is my responsibility to notify any change in my child's dietary needs in writing on this form. I give Nutrition Services consent to make modifications to my child's meals and to speak with the healthcare personnel below to discuss the dietary needs on this form.

Parent/Guardian Signature______________________________________ Date:_____________________________

Phone Number: ____________________________________ Email: ____

Which meals will the student eat from the school cafeteria? (check all that apply)

☐ Breakfast ☐ Lunch ☐ Snack/Super Snack ☐ None ***(if student does not eat from the cafeteria, modifications will not be arranged)***

REQUIRED: Section Below To Be Completed By A State Licensed Healthcare Professional Only

Does the child have a **life-threatening food allergy?*** **(check one)** ☐ **No** ☐ **Yes**

Does the child have a **Disability affecting major life activity requiring diet modification?*** **(check one)** ☐ **No** ☐ **Yes**

☐ **Food Allergy/ Food Item Omission**

Can the student consume foods where **the allergen is an ingredient**? (Ex: egg in pasta or milk in pancakes)? ☐ **Yes** ☐ **No**

Foods to Omit		**Foods to Substitute**	
☐ Fluid Cow's Milk	☐ Dairy Products (for lactose intolerance)	☐ Soy Milk	☐ Lactose Free Milk
☐ All milk-derived ingredients (for life-threatening milk allergy)	☐ Wheat/Gluten ☐ Peanuts	☐ Gluten-Free Diet	☐ Rice, Corn, other Grain
☐ Eggs	☐ Tree Nuts	☐ Equivalent Protein	☐ Soy Butter
☐ Fish	☐ Shellfish	☐ Chicken	☐ Beef
☐ Whole Corn	☐ Soy, all ingredients	☐ Egg Substitute	
Other (please specify) ___________________________		Other (please specify) _____________________	

☐ **Texture Modification** **PISD Nutrition Services is following the IDDSI Guidelines for food texture modifications. For more information on guidelines, please visits IDDSI.org**

Food Texture (select 1):	**Liquid texture (select 1):**	**Guidelines:**	**Duration:**
☐ Regular/Easy to Chew ☐ Soft & Bite Sized (IDDSI level 6) ☐ Minced & Moist (IDDSI Level 5) ☐ Pureed (IDDSI Level 4)	☐ Thin/ Regular ☐ Slightly Thick (IDDSI level 1) ☐ Mildly Thick (Nectar, IDDSI level 2) ☐ Moderately Thick (Honey, IDDSI Level 3)	☐ Pediatric ☐ Adult	☐ Year-Round ☐ Temporary: Start:_______ Stop:________

☐ **Formula:** Is the student NPO or is this a supplement to accompany an oral diet? ☐ NPO - Enteral feed ☐ Oral Supplement

Select one formula:

☐ Pediasure 1.0 Enteral ☐ Pediasure 1.0 w/Fiber Enteral ☐ Pediasure 1.0 Peptide ☐ Other: __________________

Dosage Per Meal: Breakfast:_____________ Lunch:____________ After School (if applicable): _______________

State Licensed Healthcare Professional Information

Name of Licensed Healthcare Professional (Print):__________________________________Phone:_________________

Signature of Licensed Medical Professional:____ Date:__________________

Name of Clinic/Hospital:_____________________________ Questions? Contact Nutrition Services at 713-740-0091

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