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**

<table>
<thead>
<tr>
<th>DOB</th>
<th>CAMPUS/GRADE/HR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**List any disability/diagnosis requiring meal modification**

**Life-threatening food allergy if applicable: (check foods to omit)**

- fluid milk
- peanuts
- tree nuts
- eggs
- fish
- shellfish
- wheat
- soy
- other, specify: ________________________________

**Can the student consume foods where the allergen is an ingredient in the food product/recipe?**

- yes
- no

Explain:

**Foods not allowed(specify):**

**Major life activity affected by the disability, if applicable**

- learning
- performing manual tasks
- speaking
- breathing
- hearing
- seeing
- other, specify: ________________________________

**Other instructions:**

**Physician (print name)**

**Phone**

**Physician Signature**

**Date**

Please return completed form to the campus nurse or fax to:

Brittanie Brown
HISD Food Services Director
940.538.7515