Burkburnett Independent School District
Student Diet Modification Form

A. This section to be completed by parent/legal guardian

Student name: ______________________________________ Date of birth: ____________

School: ___________________________________ Grade: __________

Parent/Guardian Contact Information:

Name (print): _______________________________ Phone #: __________________

I give BISD permission to speak with the below named physician to discuss the dietary needs described below. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to BISD.

____ ___________________

Parent signature Date

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

× Breakfast × Lunch × None

B. The following must be completed by a **licensed physician or prescribing medical authority**:

Does this child have a disability and/or anaphylactic/life-threatening food allergy? _________________

If YES, please describe the major life activities affected by the disability: ________________________

____

MEDICAL DIAGNOSIS or SPECIAL DIETARY NEED:

____

ACCOMMODATIONS NEEDED

No Fluid Dairy Milk   No Dairy Products (yogurt, cheese, etc)
No Milk Ingredients (in baked goods, etc)
No Whole Eggs   No Eggs as an Ingredient
No Wheat/Gluten   No Soy Ingredients
No Peanuts   No Tree Nuts
No Seafood
Other (please list)

____

List substitutions: ____

Major life activity affected by the disability (circle all that apply):

NONE

× Breathing × Seeing × Speaking × Learning × Eating × Hearing × Walking

× Caring for One's Self × Performing Manual Tasks × Other: ______________________________

Texture modification needed?:

NONE

Solids: × No Solids × Pureed × Chopped × Mechanical Soft × Regular

Liquids: × No Liquids × Thin × Thickened × Nectar × Honey × Pudding

Special Utensils: ____

Other: ____

I certify that the above named student needs special dietary accommodations, as described above, because of the student's disability and/or life-threatening food allergy or food intolerance/allergy, as indicated.

Name of Licensed Physician (print): ____

Physician's Signature: ____ Date: ______________

Clinic Name & Address: ______________________________________ Phone: ______________