HALLSVILLE ISD HEALTH SERVICES
FOOD ALLERGY/DISABILITY SUBSTITUTION REQUEST FORM

Form is to be completed by an authorized medical professional.
Return completed copy to your campus nurse.
Phone: 903-668-5990 Fax: 903-668-5991
Information submitted to Skyward at enrollment is not a substitution for this form.
This must be on file for any cafeteria dietary changes.

PART 1: TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name:	Student ID #:	
School:	Grade Level:	DOB:
Parent/Guardian Name:	Relationship to Student:	
Email:	Daytime Phone #:	
Mailing Address:	City:	Zip Code:

Which meal(s) will your student be eating from the school cafeteria? ☐ Breakfast ☐ Lunch

PART 2: MUST BE COMPLETED BY STUDENT'S TREATING PHYSICIAN (PLEASE PRINT)

Does the student have an identified disability, food allergy, or food intolerance requiring a special diet?

If YES: Complete PART 2 ⬇ **If NO: A special diet is not required**

☐ **SEVERE ALLERGY:** Student has a food allergy that is severe or causes an anaphylactic reaction
☐ **MILD ALLERGY:** Student has a food allergy that is less severe or does not cause an anaphylactic reaction
☐ **FOOD INTOLERANCE:** Student has a food intolerance that requires a modified diet
☐ **DISABILITY:** Student has a disability that requires a modified diet

Please choose foods to omit from a student's diet during the school day (select all that apply).

Dairy
☐ Lactose Intolerance
☐ Fluid Dairy Milk Only
☐ All Plain Dairy Products
☐ All menu items with dairy as an ingredient
☐ Juice is an acceptable substitute for fluid milk for a milk allergy or intolerance

Eggs
☐ Whole Eggs (i.e. scrambled, hard-boiled)
☐ All menu items with eggs as an ingredient

Soy
☐ Soy protein
☐ Soybean oil
☐ All menu items with soy ingredients (incl. soy lecithin, oil)

Nuts
☐ Peanuts
☐ Tree Nuts

Fish/Shellfish
☐ Fish
☐ Shellfish

Wheat/Gluten
☐ All menu items with wheat as an ingredient
☐ Celiac

☐ **Other:** Please Specify: _____

☐ **Texture Modification:** Please Specify (blended, chopped, thickener, etc): _____

I certify that the above named student requires food substitutes as described above due to their disability, food allergy, or food intolerance.

Medical Authority Name (Printed): Phone Number:

Medical Authority Signature: Date:

Food services will attempt to accommodate the substitutions as requested,
but reserves the right to modify the menu base on product availability.

Parent signature_____Date_____

Campus Nurse_____Date_____

Food Services Representative_____Date_____

THIS FORM IS VALID FOR THE CURRENT SCHOOL YEAR ONLY.