# Meal Substitution Request Form – *Medical Purposes*

CONROE
INDEPENDENT
SCHOOL DISTRICT

In accordance with U.S. Department of Agriculture regulations CISD will provide meal substitutions when medically necessary for a student to access the District's meal program. If your child has a medical condition that requires meal substitutions, complete and return this form to the nurse at your child's school.

## **Part 1:** To be completed by parent/guardian. *Please print.*

______________________ *Student ID* ______________________ *Student's First Name* ______________________ *Student's Last Name*

______________________ *Student's Date of Birth* ______________________ *School*

______________________ *Parent/Guardian's Name* ______________________ *Email Address*

Work Phone: ( _______ ) __________________ Cell Phone: ( _______ ) __________________ Home Phone: ( _______ ) __________________

## **Part 2:** To be completed by licensed physician (physician's assistant or nurse practitioner). *Please print.*

Describe the student's medical condition and how it affects the student's diet and participation in the District's meal program: ______________

______________________________________________________________________

If the medical condition is a ***severe food allergy***, please provide the following information:

The student has a life-threatening food allergy to:

☐ Peanuts ☐ Tree nuts ☐ Milk ☐ Fish ☐ Shellfish ☐ Eggs ☐ Soy ☐ Wheat

☐ Other: ______________________________________________________________

Do the allergy symptoms occur when the allergen is used as an ingredient in a product? ☐ Yes ☐ No

***Example:*** *If the student has an egg allergy in which egg patties trigger a reaction but baked products that contain eggs do not trigger a reaction, then the answer is no.*

List all foods to be omitted from the student's diet ***and*** approved substitutions for those foods: ______________________________

______________________________________________________________________

______________________________________________________________________

If the student requires modification to food texture or consistency, please describe what is medically necessary: ________________

______________________________________________________________________

Describe any other considerations necessary to allow the student to participate in the District's meal program: ________________

______________________________________________________________________

LHP's name: ______________________________________ Office phone: ( ______ ) __________________

______________________________________ *LHP's signature* ______________________ *Date*

***LHP - Licensed Health provider - licensed physician, physician's assistant or nurse practitioner***

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**Conroe ISD Child Nutrition**
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