



# GALENA PARK I.S.D. CHILDCARE CENTER

South Campus ♦ 1906 2nd St. Galena Park, TX 77547  
Phone 832-386-3760 ♦ Fax 832-386-2013

North Campus ♦ 325 Barbara Mae, Houston, TX 77015  
Phone 832-386-2090 ♦ Fax 832-386-2091

## Diaper Cream/Ointment Authorization Form

<b>Child's Name:</b>	<b>Date of Birth:</b>
<b>Name of Medication/Cream to be applied: (can state over the counter diaper rash cream)</b>	
<b>Times to be applied:</b> <input type="checkbox"/> When rash is present <input type="checkbox"/> With every diaper change <input type="checkbox"/> Other:	<b>Amount to be applied:</b>
<b>Special Instructions:</b>	

**Reason for medication:** For diaper rash prevention or treatment

**Route:** Topical

**Storage:** Room temperature

I authorize the use of the above diaper cream/ointment on my child.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Health Care Provider Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Health Care Provider Printed**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Health Care Provider Phone Number**

**\*\*New form must be filled out each school year\*\***



# FRESH FOOD. MINDS.

## Physician's Request for Special Dietary Accommodations Galena Park ISD Student Nutrition

All requests are subject to GPISD approval and provision based on policy and procedure

All Sections must be completely filled out for this form to be accepted.

\*Indicates required field.

DATE: \_\_\_\_\_

SCHOOL YEAR: \_\_\_\_\_

### A. THIS SECTION TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

\*Student Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Student ID: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

School Nurse: \_\_\_\_\_ Phone: \_\_\_\_\_

I give Health Services/Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### B. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

\*Does the child have a disability and/or anaphylactic/life-threatening food allergy?  YES  NO *If YES selected, form must be completed and signed by licensed physician.*

\*If YES, please describe the major life activities affected by the disability: \_\_\_\_\_

\*MEDICAL DIAGNOSIS: \_\_\_\_\_

### ACCOMMODATIONS NEEDED Lactose Free milk or Soy Milk is the standard substitution when Fluid Dairy Milk please prescribe under Substitutions ^

No Fluid Dairy Milk^  No Dairy Products (yogurt, cheese, etc.)  No Milk Protein/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 foods processed in a facility that contains nuts  No Seafood

Other (Please list) \_\_\_\_\_

Substitutions \_\_\_\_\_

#### I. Texture Modification: NONE

Duration: (choose one)

Year-Round

Temporary: Start \_\_\_\_\_ Stop \_\_\_\_\_

Liquids: (choose one)

Mildly Thick (Level 2)

Moderately Thick (Level 3)  Minced & Moist (Level 5)

Extremely Thick (Level 4)  Pureed (Level 4)

Solids: (choose one)

Soft & Bite-Sized (Level 6)

#### III. Supplement: NONE

NPO  Supplement to accompany oral diet

Boost Kid Essentials 1.5  Pediasure  Pediasure with Fiber  Pediasure with Fiber 1.5  Pediasure Enteral with Fiber 1.0

Other : \_\_\_\_\_ *\*Supplements may take up to 6 weeks to be processed.*

Dosage Per Meal (REQUIRED): \_\_\_\_\_ Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ After School Supper

IV. Therapeutic Diet Order: Please provide specifics as needed. \_\_\_\_\_

**C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY**

*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.*

MD  DO  NP  PA

**\*Signature of Licensed Physician/Prescribing Medical Authority Date**

**\*Printed Name of Licensed Physician/Prescribing Medical Authority**

Phone Fax

Address

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**Send completed form to school nurse. Please submit new Physician Request form each school year. Any change or discontinuation must be submitted in writing by the physician. Please allow two business weeks for processing. Scan completed forms to [ALGRANT@galenaparkisd.com](mailto:ALGRANT@galenaparkisd.com) or call 832-386-1549 with questions or return to the school nurse for further processing.**

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# FRESH FOOD. FRESH MINDS.

## Galena Park ISD Solicitud médica para realizarle modificaciones especiales a la dieta de un menor

Fecha: \_\_\_\_\_

No se aceptará el formulario si no se han llenado todas las secciones. El \* indica dato requerido.

Ciclo escolar: \_\_\_\_\_

### A. ESTA SECCIÓN DEBE LLENARLA EL PADRE O TUTOR

\*Nombre del estudiante: \_\_\_\_\_ Fecha de Nac.: \_\_/\_\_/\_\_

Escuela: \_\_\_\_\_ Grado: \_\_\_\_\_ ID: \_\_\_\_\_ Padre o

tutor: \_\_\_\_\_ Teléfono: \_\_\_\_\_

Enfermera de la escuela: \_\_\_\_\_ Teléfono: \_\_\_\_\_

*Doy mi autorización para que los Servicios de Salud o los Servicios de Nutrición hablen con el doctor o la autoridad médica que se menciona más adelante para discutir las necesidades de alimentación que se describen a continuación:*

Firma del padre o tutor: \_\_\_\_\_ Fecha: \_\_\_\_\_

### B. ESTA SECCIÓN DEBE LLENARLA UN MÉDICO LICENCIADO O LA AUTORIDAD MÉDICA PERTINENTE

\*¿Tiene el niño una discapacidad o una alergia alimentaria que podría provocar anafilaxis o poner en peligro su vida?  SÍ  NO  
*Si marcó SÍ, un médico licenciado debe llenar y firmar este formulario.*

\*Si respondió SÍ, indique las actividades importantes afectadas por la discapacidad: \_\_\_\_\_

\*DIAGNÓSTICO MÉDICO: \_\_\_\_\_

### MODIFICACIONES NECESARIAS ^La leche de lactose free la leche líquida de origen or Soy la leche

#### I. Restricciones necesarias: NINGUNA

- No consumir leche de lactose free      ^       No consumir productos lácteos (yogur, queso, etc.)       No consumir proteína láctea o ingredientes lácteos (en alimentos horneados, etc.)
- No consumir huevo entero       No usar huevos como ingrediente
- No consumir trigo o gluten       No consumir soya
- No consumir maní       No consumir frutos secos (*Tenga presente que HISD no incluye maní o frutos secos en sus menús*).
- No consumir alimentos procesados en instalaciones donde haya habido nueces       No consumir mariscos
- Otras (anote) \_\_\_\_\_

Alimentos sustitutos \_\_\_\_\_

#### II. Modificación de la textura: NINGUNA

Líquidos: (marque una)      Sólidos: (marque una)

Duración: (marque una)

- Durante todo el año       Levemente espeso (Nivel 2)       Blando y tamaño de bocado (Nivel 6)
- Temporalmente: Iniciar \_\_\_\_\_ Terminar \_\_\_\_\_       Medianamente espeso (Nivel 3)       Molido y húmedo (Nivel 5)
- Sumamente espeso (Nivel 4)       Hecho puré (Nivel 4)

#### III. Suplementos: NINGUNA

- Nil per os (No ingerir nada por vía oral)       Algún suplemento acompañará la dieta oral
- Boost Kid Essentials 1.5       Pediasure       Pediasure con fibra       Pediasure con fibra 1.5       Pediasure Enteral con fibra 1.0

Otro: \_\_\_\_\_ *\*Podría tomar hasta 6 semanas incorporar suplementos que no se hayan indicado anteriormente.*

Dosis por alimento (ES REQUISITO):      \_\_\_Desayuno      \_\_\_Almuerzo      \_\_\_Colación al término de las clases

IV. Orden de dieta terapéutica: Por favor ofrezca datos específicos: \_\_\_\_\_

**C. ESTA SECCIÓN DEBE LLENARLA UN MÉDICO LICENCIADO O LA AUTORIDAD MÉDICA PERTINENTE**

*Yo certifico que el estudiante que se menciona arriba necesita las modificaciones dietéticas descritas, dado que presenta una discapacidad o una alergia alimentaria severa provocada por alimentos que ponen en riesgo su vida, como ya se ha mencionado.*

MD DO NP PA

**\*Firma del doctor o autoridad médica**

**Fecha**

**\*Nombre del doctor o autoridad médica**

Teléfono

Fax

Domicilio

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*Entregue el forma lleno a la enfermera de la escuela. Deberá presentar uno nuevo cada año. Todo cambio o terminación de tratamiento debe comunicarse por escrito, de parte del médico. El trámite toma dos semanas. Mande la forma por scan a [ALGRANT@galenaparkisd.com](mailto:ALGRANT@galenaparkisd.com) con preguntas contacte 832-386-1549 or return to school nurse for further processing..*

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# FRESH FOOD. FRESH MINDS.

## Physician's Request for Special Accommodations for Formula & Infant Food Galena Park ISD Student Nutrition

All requests are subject to GPISD approval and provision based on policy and procedure

All Sections must be completely filled out for this form to be accepted.

\*Indicates required field.

DATE: \_\_\_\_\_

SCHOOL YEAR: \_\_\_\_\_

### A. THIS SECTION TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

\*Student Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

School: \_\_\_\_\_ Age/Class: \_\_\_\_\_ Student ID: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

School Nurse: \_\_\_\_\_ Phone: \_\_\_\_\_

*I give Health Services/Student Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.*

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### B. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN /PRESCRIBING MEDICAL AUTHORITY

\*Does the child have a disability and/or anaphylactic/life-threatening food allergy?  YES  NO

*If YES selected, form must be completed and signed by licensed physician.*

\*If YES, please describe the major life activities affected by the disability: \_\_\_\_\_

\*MEDICAL DIAGNOSIS: \_\_\_\_\_

\*Qualifying Conditions/Diagnosis – Please Check all that Apply

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> cardiovascular condition                 | <input type="checkbox"/> low maternal weight gain/loss                              | <input type="checkbox"/> GER/GERD           |
| <input type="checkbox"/> malabsorption syndrome                   | <input type="checkbox"/> inadequate growth  | <input type="checkbox"/> tube feeding       |
| <input type="checkbox"/> developmental delays (sensory and motor) | <input type="checkbox"/> neurological condition                                     | <input type="checkbox"/> prematurity/LBW    |
| <input type="checkbox"/> GI impairment                            | <input type="checkbox"/> respirator condition                                       | <input type="checkbox"/> FTT                |
| <input type="checkbox"/> seizure disorder requiring ketogenic     | <input type="checkbox"/> food allergies (cow's milk, soy or intact proteins ) FPIES | <input type="checkbox"/> oral motor feeding |
| <input type="checkbox"/> renal disease/low mineral condition      | <input type="checkbox"/> other medical condition                                    |   |

\_\_\_\_\_  
\_\_\_\_\_

### Formula Options:

- Similac Sensitive (lactose sensitivity or colic)
- Similac for Spit-Up (excess spit-up or reflux)
- Similac Total Comfort (digestive issues or colic)

**Infant Supplement Foods: - Optional**

Infant 6 to 11 months of age:

Check Foods to remove from menu

- Infant cereal
- Baby food (due to inability or delay in consuming solids)  
*(specify food items below)*

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**C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY**

*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.*

MD DO NP PA

**\*Signature of Licensed Physician/Prescribing Medical Authority Date**

**\*Printed Name of Licensed Physician/Prescribing Medical Authority**

Phone Fax

Address

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