



Physician's Request For Non-Standard Formula & Infant Food

THIS SECTION IS TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Student Name: _____ Date of Birth: _____
 School Name: _____ Student ID: _____
 Parent/Guardian Name: _____ Phone: _____

As parent or guardian, I give permission for Galena Park ISD to contact the physician's office regarding my child's dietary needs.

Parent Signature: _____ Date: _____

THIS SECTION IS TO BE COMPLETED BY LICENSED PHYSICIAN

The US Department of Agriculture School Meals Program requires that **ALL** questions be answered in order for ANY diet modification or substitution to be made

Does the child have a disability and/or life-threatening food allergy requiring diet modification? Yes No

Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, define a person with disability as any person who has a physical or mental impairment which substantially limits one or more "major life activities, has a record of such impairment, or is regarded as having such impairment".

If YES, please describe the major life activities affected: _____

*If the student does NOT have a disability and/or food allergy, this form does not need to be completed and will be disregarded

Medical Diagnosis: _____

Qualifying Conditions: (Please check all that applies)

All changes or updates to diet modifications must be provided in writing by a Licensed Physician

- | | | |
|--|--|--|
| <input type="checkbox"/> Cardiovascular condition | <input type="checkbox"/> Tube feeding | <input type="checkbox"/> Malabsorption/Maldigestion |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> FTT | <input type="checkbox"/> GER/GERD |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> GI disorder | <input type="checkbox"/> Renal disorder |
| <input type="checkbox"/> Respiratory condition | <input type="checkbox"/> Inadequate growth | <input type="checkbox"/> Food allergies (cow's milk, soy, or intact protein)/FPIES |
| <input type="checkbox"/> Oral motor feeding issues | <input type="checkbox"/> Prematurity/LBW | |
| <input type="checkbox"/> Other: _____ | | |

Formula Options:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Similac Soy Isomil
<i>(soy-based)</i> | <input type="checkbox"/> Enfamil Gentlease
<i>(for mild lactose intolerance)</i> | <input type="checkbox"/> Enfamil A.R.
<i>(for mild lactose intolerance)</i> | <input type="checkbox"/> Enfamil Reguline
<i>(for mild lactose intolerance)</i> |
| <input type="checkbox"/> Other: _____ | | | |

Infant Food: (if applicable) Check Foods to **remove** from the menu

- | | | |
|--|---|---|
| <input type="checkbox"/> Infant cereal | <input type="checkbox"/> Baby food*
<i>(due to delay or inability to consume solids)</i> | <input type="checkbox"/> Formula only, no foods
<i>(due to delay or inability to consume solids)</i> |
|--|---|---|

*Please specify food item to omit: _____

I, _____, physician for _____, declare the herein mentioned child Physician's Name Child's Name to possess the following listed Life Threatening Food Allergies and/or Disabilities. Alternate foods should be offered at school in accordance with the following guidelines.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Clinic Name: _____ Clinic Address: _____

Send the completed form to the school nurse and forward a copy to tvo@galenaparkisd.com.
Please allow two business weeks for processing.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.