



# Physician's Request For Special Dietary Accommodations

## THIS SECTION IS TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School Name: \_\_\_\_\_ Student ID: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Parent's Email: \_\_\_\_\_

Which meals will the student be eating from the school cafeteria?

Breakfast  Lunch  Supper

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

Does the student have a prescription for an Epi-pen for a food allergy? Yes  No

Medical Diagnosis: \_\_\_\_\_

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

- Peanuts  Tree Nuts  Fish/Seafood  Shellfish  Eggs by themselves  Eggs as an ingredient  
 Soy as main ingredient  All food containing soy  Wheat/Gluten  Fluid Milk  
 Dairy products (cheese, yogurt, etc.)  Other: \_\_\_\_\_

Substitutions: \_\_\_\_\_

Other accommodations needed:

Texture Modification: **Solids:**

- Soft & Bite-Sized (Level 6)  
 Minced & Moist (Level 5)  
 Pureed (Level 4)  
 None

**Liquids:**

- Extremely Thick (Level 4)  
 Moderately Thick (Level 3)  
 Mildly Thick (Level 2)  
 Slightly Thick (Level 1)  
 None

Supplements (if any): \_\_\_\_\_

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](mailto:tvo@galenaparkisd.com).  
 Please allow two business weeks for processing.

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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](mailto:program.intake@usda.gov)

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