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:** _____

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.
Please allow two business weeks for processing.