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

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

Formula Options:

- ☐ Similac Sensitive *(lactose sensitivity or colic)*
- ☐ Similac for Spit-Up *(excessive spit-up)*
- ☐ Similac Total Comfort *(digestive issues or colic)*
- ☐ Other: _____

Infant Food: *(If applicable)*

Check Foods to **remove** from the menu

- ☐ Infant cereal
- ☐ Baby food* *(due to delay or inability to consume solids)*
- ☐ Formula only, no foods *(due to delay or inability to consume solids)*

*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.