

Physician's Request for Dietary Accommodations

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

School Year: _____

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

Student Name (Last, First): _____ Date of Birth: ___/___/___
 Campus: _____ Grade: _____ Student ID: _____
 Which meals will the child consume at school? (please circle) Breakfast Lunch Will bring meals from home
 Parent/Guardian Name (please print): _____ Phone: _____
 Email Address: _____
I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the school nurse and the dietitian.
 Signature: _____ Date: _____

B. PARENT / LEGAL GUARDIAN CAN DECLINE ACCOMMODATIONS BELOW

I/We, _____ (Parent/Guardian) of _____ (Student) **DO NOT** wish to participate in the Dietary Accommodation program.
 Signature: _____ Date: _____

C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN

Does the child have a disability or anaphylactic/ life threatening food allergy? Yes No
Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more life activities, has a record of such an impairment or is regarded as having such an impairment.
If yes, please describe the major life activities affected by the disability: _____
Medical Diagnosis (REQUIRED): _____
Check Foods to be Omitted:
 ___ Peanuts ___ Tree Nuts ___ Soy ___ All Soy Protein (oil, lecithin, etc.) ___ Fish ___ Shellfish
 ___ Fluid Milk ___ Fluid Milk & Dairy ___ All Milk Protein (casein, whey, etc.) ___ Egg ___ Wheat/ Gluten
 ___ Other (please be specific): _____
Can the student consume foods when the allergen is an ingredient in the food product? Yes No
(example: whole eggs and scrambled eggs are omitted however egg as an ingredient in pancakes and waffles are allowed)
 Explain: _____
Texture Modification
 List foods that need the following texture modification. If all foods need to be prepared in this manner, indicate "ALL".
 Bite size pieces: _____ Finely chopped: _____ Pureed: _____
 Other (please be specific): _____

Clinic/ Facility Name: _____ Phone: _____
 Address: _____
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.
 Physician Name (please print): _____ Date: _____
 Physician Signature: _____

Send completed form to school nurse. Physician request forms **MUST** be renewed each school year. Any change or discontinuation must be submitted in writing by the physician. The Child Nutrition Department may make food substitutions, at their discretion, for individual students who do not have a disability but who are medically certified as having a special medical or dietary need.

For questions about this form please contact LCISD Dietitian: Kasandra Davis, RD, LD. Phone: 832-223-0188, Fax 832-223-0187 or email kdavis02@lcisd.org

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