### PART A: THIS SECTION TO BE COMPLETED BY A PARENT/LEGAL GUARDIAN

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Age:</th>
<th>Student ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Classroom:</td>
</tr>
<tr>
<td>Printed Parent or Guardian’s Name:</td>
<td>E-mail:</td>
<td>Phone:</td>
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</tbody>
</table>

### PART B. THIS SECTION TO BE COMPLETED BY A MEDICAL AUTHORITY LICENSED BY THE STATE OF TEXAS TO WRITE MEDICAL PRESCRIPTIONS

Medical authority licensed by the state of Texas to write medical prescriptions is required to complete PART B and sign.

1. Does the Child have a disability recognized by the American’s with Disability Act (ADA)?
   - YES
   - NO
   If NO, skip to Question # 3

2. If YES, please identify the disability and describe the major life activities affected by the disability.

3. If the Child does not have a disability, does the child have a food allergy or intolerance that results in an anaphylactic reaction when exposed to the food (s) to which they have problems?
   - YES
   - NO

4. If the answer to Questions 1 or 3 is YES, please check the following that affect the child.
   - Dairy
     - Fluid Milk
     - Cheese
     - Yogurt
     - Menu items with any dairy ingredients
   - Eggs
     - Whole Eggs (such as scrambled or boiled eggs)
     - Menu items with eggs listed as ingredient
   - gluten
   - Wheat
   - Peanut
   - Tree Nut(s)
   - Soy Protein
   - Sesame
   - Fish
   - Shellfish
   - Other:

   Any additional information:

5. For food texture modification. List the foods that need the following change in texture. If all foods need to be prepared in this manner, indicate “all”
   - (a) Cut up or chopped into bite size pieces.
   - (b) Finely ground.
   - (c) Pureed or Blended.

6. Indicate any other comments about the child’s eating or feeding patterns.

    Office Phone: __________________ Office Fax: ________________

    Medical authority’s printed or stamped name

    ___________________________ ___________________________ Date

### PART C. THIS SECTION TO BE COMPLETED BY SCHOOL NURSE

<table>
<thead>
<tr>
<th>School Nurse:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Does the Child have “Individualized Health Care Plan” (IHCP)?
   - YES
   - NO

8. Does the Child have a 504 Plan?
   - YES
   - NO

Austin ISD is an equal opportunity provider.