AUSTIN Independent School District

Request for Dietary Accommodation

Please complete this form and provide a copy to the school cafeteria. The Parent/Legal Guardian and School Nurse will be notified after the request is evaluated by the Dietitian.

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

Student's Name:		Age:	Student ID:
School:	Grade:	Classroom:	
Printed Parent or Guardian's Name:		E-mail:	
		Phone:	

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.

_____ Medical authority's printed or stamped name	Office Phone: _____ Office Fax:_____
_____ Medical authority's signature	_____ Date

PART C. THIS SECTION TO BE COMPLETED BY SCHOOL NURSE

School Nurse:	Phone:

7. Does the Child have "Individualized Health Care Plan" (IHCP)? ◯ YES ◯ NO

8. Does the Child have a 504 Plan? ____ YES ____NO