

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.

- Does the Child have a disability recognized by the American's with Disability Act (ADA)?
 ___YES ___NO If NO, skip to Question # 3
- If YES, please identify the disability and describe the major life activities affected by the disability.
- 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
- If the answer to Questions 1 or 3 is YES, please check the following that affect the child.

<u>Dairy</u>	<u>Eggs</u>
<input type="checkbox"/> Fluid Milk <input type="checkbox"/> Cheese <input type="checkbox"/> Yogurt	<input type="checkbox"/> Whole Eggs (such as scrambled or boiled eggs)
<input type="checkbox"/> Menu items with any dairy ingredients	<input type="checkbox"/> Menu items with eggs listed as ingredient
<input type="checkbox"/> Gluten <input type="checkbox"/> Wheat <input type="checkbox"/> Peanut <input type="checkbox"/> Tree Nut(s)_____ <input type="checkbox"/> Soy Protein <input type="checkbox"/> Sesame <input type="checkbox"/> Fish <input type="checkbox"/> Shellfish	
<input type="checkbox"/> Other: _____	
- Any additional information:
- 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"
 - Cut up or chopped into bite size pieces. _____
 - Finely ground. _____
 - Pureed or Blended. _____
- 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	