

Physician's Request for Dietary Accommodations



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

School Year: _____

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. Please allow **3 weeks** for processing. If you have questions about this form you may contact the Child Nutrition Department at 713-251-1150 / SpecialDiets@springbranchisd.com

THIS SECTION TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

Student Name (Last, First): _____ Date of Birth: ____/____/____

Campus: _____ Grade: _____ Student ID: _____

Parent/Guardian Name (please print) _____

Email Address: _____ Phone Number: _____

Which meals will the child consume at school (please check all that apply)

- Breakfast
 Lunch
 Afterschool Snack
 None, child will bring meals from home
 (no accommodation needed, only post alert)

I give SBISD Child Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below. 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 Spring Branch ISD. I acknowledge that a la carte purchases are not monitored by the cafeteria for allergens. If I would like to prevent my child from purchasing any a la carte items, I may set these purchasing restrictions on www.SchoolCafe.com/springbranchisd

Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

Does the student have a disability and/or food allergy requiring a diet modification? Yes No

If student does NOT have a disability and/or food allergy, this form DOES NOT need to be completed and will be disregarded

Does the student have a prescription for an Epi-Pen for a food allergy? Yes No

Medical Diagnosis: _____

Major life activities affected by the disability: _____

ACCOMODATIONS NEEDED

I. Food to be Omitted None

- Peanuts Treenuts (please note that SBISD does not serve peanuts or tree nuts on the regular menu)
 Sesame Fish Shellfish
 Milk (Fluid Dairy) Dairy Products (yogurt, cheese, etc) Milk Protein/ Milk Ingredients (in baked goods, etc)

Please note the type of dairy free milk you wish to be substituted for fluid milk Vanilla Soy Milk Lactaid None. ****Juice cannot be substituted for milk****

- Eggs (whole, cooked) Egg as ingredient (in baked goods, breading, mayo)
 Soy as a main ingredient (edamame, soy sauce, soy milk) Soy as a minor ingredient (soy in processed foods: soybean oil, soy lecithin)
 Wheat/Gluten

Other, please list _____

Substitutions: _____

I. Texture Modification None

Duration: (choose one)

- Year Round
 Temporary:

Start _____ Stop _____

Liquids: (choose one)

- Mildly Thick (Level 2)
 Moderately Thick (Level 3)
 Extremely Thick (Level 4)

Solids: (choose one)

- Soft & Bite-sized (Level 6)
 Minced & Moist (Level 5)
 Pureed (Level 4)

I certify that the above named student needs to be offered food substitution as described above because of the student's disability and/or life threatening food allergy.

Name of Licensed Physician (print): _____

Physician Signature: _____

Clinic Name & Address: _____ Phone: _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

Dietary Accommodations Discontinuation



Parent/Legal Guardian

All fields must be completed. The SBISD Child Nutrition Services shall no accept incomplete forms. Write "n/a" if field no applicable

Student Name: _____ Student ID#: _____

DOB (mm/dd/yyyy): _____ Name of School: _____

Grade Level _____

Parent/Legal Guardian Name: _____

Phone Number: _____ Email: _____

Previously prescribed Dietary accommodations

All dietary accommodations listed above have been discontinued. Alerts on students accounts will be removed.

Parent/Guardain Signature: _____ Date: _____