Physician's Request for Dietary Accommodations

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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 accomodation 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 diasbility 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 fo 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) ☐ Diary 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 substitued 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)	**Liquids: (choose one)**	**Solids: (choose one)**
☐ Year Round	☐ Mildly Thick (Level 2)	☐ Soft & Bite-sized (Level 6)
☐ Temporary:	☐ Moderately Thick (Level 3)	☐ Minced & Moist (Level 5)
Start_____ Stop_____	☐ Extremely Thick (Level 4)	☐ 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: _____

Dietary Accomodations Discontinuation

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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:_____

Previoiusly prescribed Dietary accomodations
All dietary accomodations listed above have been discontinued. Alerts on students accounts will be removed. Parent/Guardain Signature:_____ Date:_____