Request for Dietary Accommodation

Instructions: Part A: Parent/Guardian completes
Part B: Physician completes
Part C: School Nurse completes. Nurse to keep a copy
Scan and e-mail to Joyce Fox, Director of School Nutrition, joycef@fisd.org
Parent/Guardian and School Nurse will be notified after request is evaluated.

Instrucciones: Padre o Tutor completa PARTE A. El Médico completa PARTE B. Enfermera Escolar completa
PARTE C. Padre o Tutor y Enfermera de la escuela serán notificados después de evaluar la solicitud.
Escanee y envíe un correo electrónico a Joyce Fox, Directora de Nutrición Escolar, joycef@fisd.org Se notificará a los padres / tutores y la enfermera escolar después de que se evalúe la solicitud

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

PART B		
Physician licensed to practice medicine in the state of Texas 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 ____ Egg ____ Egg White ____ Gluten ____ Nut(s)____ Soy ____ PKU ____ 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.		
Licensed physician's printed or stamped name _____	Office Phone: _____ Office Fax/Email : _____	
Licensed physician's signature _____	Date: _____	

School Nurse: PART C		
7. Does the Child have "Individualized Health Care Plan" (IHCP).	YES	NO
8. Does the Child have a 504 Plan?	YES	NO