Galveston ISD Child Nutrition Department
409-766-5162 (Fax) 409-766-7040

FAX TO: 409-766-7040 ATTN: Jennifer Douglas

PHYSICIAN'S DIET MODIFICATIONS

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Parent/Guardian Name____________________________Student Name______________________________________
Campus Name____________________________________Date of Birth ______________________________
As parent or guardian, I give **permission for Galveston ISD to contact the Physician's office** regarding my child's dietary needs. ____________________________(Signature)

PART A – STUDENTS WITH

LIFE THREATENING FOOD ALLERGIES ONLY COMPLETE THIS PART

(If there is NO LIFE THREATENING FOOD ALLERGY, SKIP THIS SECTION, and GO TO PART B on back of page)

PHYSICIAN'S STATEMENT Date _________________________

I___________________________________, (physician) declare the child listed above to possess
Physician's Name (please PRINT)
the following LIFE THREATENING FOOD ALLERGY.

1. Life threatening food allergy – Omit these foods:
____fluid milk ____peanuts ____tree nuts ____eggs ____fish ____shellfish ____wheat ____soy

2. Can the student consume foods where the allergen is an ingredient in the food product? _____yes _____no
(Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)
Explain____

3. Other life threatening food allergies (list all) – Omit these foods:

____

4. Explanation of why this disability restricts diet: ____

5. Major life activity affected by the life threatening food allergy (check all that apply):
(*NOTE: .Galveston cannot honor this document unless at least one life activity is marked.)*
_____eating ____caring for one's self ____performing manual tasks ____walking ____seeing
_____hearing _____speaking ____breathing ____learning

6. Foods to Substitute (*NOTE: .Galveston ISD cannot honor this document unless substitutions are listed below.)*

____

____
Physician's Signature

____ ____
Telephone Clinic/Facility Name & Address

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 aprogram 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 2. Fax: (833) 256-1665 or (202) 690-7442; or 3. Email: program.intake@usda.gov. This institution is an equal opportunity provider.

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Parent/Guardian Name____________________Student Name______________________Date of Birth_________
As parent or guardian, **I give permission for Galveston ISD to contact the Physician's office** regarding my child's dietary needs. ______________________________(Signature)

PART B – STUDENTS WITH DISABILITIES COMPLETE THIS

PHYSICIAN'S STATEMENT

Date ____________________________

I_____________________________, **(physician) declare the child listed at top of page to possess**
Physician's Name (please PRINT)
the following DISABILITY.

1. List any disability requiring meal modification: ____

2. Explanation of why this disability restricts diet: ____

3. Major life activity affected by the DISABILITY (check all that apply):
(NOTE: Galveston ISD cannot honor this document unless at least one life activity is marked.)
_____eating ____caring for one's self ____performing manual tasks ____walking ____seeing
_____hearing _____speaking ____breathing ____learning ____other, specify_________________________

4. Foods to Omit:

____
____
____

5. Foods to Substitute (***NOTE: Galveston ISD cannot honor this document unless substitutions are listed below.)***

____
____

____
Physician's Signature

____ ____
Telephone Clinic/Facility Name & Address

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