Physician's Request for Dietary Accommodations

All sections must be **COMPLETELY** filled out for this form to be accepted. **School Year:** _____

A. 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)**:** _____ **Phone:** _____

Email Address: _____

I give Sheldon ISD Child Nutrition and/or Campus Nurse permission to speak with the Physician listed below to discuss the dietary needs described on this form.

Signature: _____ **Date:** _____

B. PARENT / LEGAL GUARDIAN CAN DECLINE ACCOMMODATIONS BELOW

I, _____(Parent/Guardian) of _____(Student) do not wish to participate in the Food Allergy program. I release Sheldon Independent School District, including its officers and employees, from any liability arising from their negligent acts or omissions that are in any way related to my student's food allergy.

Signature: _____ **Date:** _____

C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN

Does the child have a disability or anaphylactic/ life threatening food allergy? Yes No

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more life activities, has a record of such an impairment or is regarded as having such an impairment.

If yes, please describe the major life activities affected by the disability: _____

Medical Diagnosis: _____

Check Foods to be Omitted: ____ Peanuts ____ Tree Nuts ____ Products produced in a facility containing any nuts

____ Soy ____ All Soy Protein (oil, lecithin, etc.) ____ Whole Eggs (yolk, whites) ____ All Egg Protein (baked goods)

____ Fluid Milk ____ Dairy(cheese,yogurt) ____ All Milk Protein (casein, whey) ____ Fish ____ Shellfish ____ Wheat

____ Other (please be specific): _____

Milk Substitution (for disability/life threatening food allergy): _____ or

____ *check if no milk or substitute is to be provided*

Can the student consume foods when the allergen is an ingredient in the food product? Yes No

(example: whole eggs and scrambled eggs are omitted however egg as an ingredient in pancakes and waffles are allowed)

Explain: _____

Texture Modification

List foods that need the following texture modification. If all foods need to be prepared in this manner, indicate "ALL".

Bite size pieces: Finely chopped: Pureed:

Other (please be specific): _____

Clinic/ Facility Name: _____ Phone: _____

Address: _____

I certify that the above named student needs special dietary accommodations, as described above because of the student's disability and/ or life threatening food allergy or food intolerance/allergy as indicated.

Physician Name (please print): _____ Date: _____

Physician Signature: _____

Send completed form to Child Nutrition Department or school nurse. *Physician request forms **MUST** be renewed each school year. Any change or discontinuation must be submitted in writing by the physician. The Food Services Department may make food substitutions, at their discretion, for individual students who do not have a disability but who are medically certified as having a special medical or dietary need.*

For questions about this form please contact Sheldon ISD Food Services Dietitian: Susan Nayeri. Phone: 281-727-1441, Fax: 281-459-1247 or email susannayeri@sheldonisd.com

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