HEB
HURST - EULESS - BEDFORD
Independent School District

Child Nutrition Services Department
Disability / Severe Food Allergy Request Form Instructions

1. **Students with disabilities as defined under Section 504 of the Rehabilitation Act of 1973, the American Disabilities Act of 1990 (ADA), the Education of the Handicapped Act (IDEA) and students with a physician's assessment of food allergies that may result in a severe, life-threatening (anaphylactic) reaction will be accommodated regarding special diets as specified by a licensed physician.**

2. Students with disabilities and/or life threatening food allergies requiring meal modifications must provide a statement that explains the need. It must be signed by a recognized medical authority (physician, physician assistant or advanced practice nurse). Under no circumstances are Food & Nutrition Services Staff allowed to revise or change a diet prescription or medical order.

3. Parent/legal guardian is responsible for providing the required documentation for such requests. After completing the disability/severe food allergy request form, please return to:
   Child Nutrition Services Department
   Mariella Naugher RD, LD, SNS
   1350 W. Euless, Bldg A
   Euless, TX 76040
   Phone: 817.399.2120
   Fax: 817.354.3562

4. Parent/legal guardian will be contacted by the Child Nutrition Department if needed for approval/denial of a disability/severe food allergy request.

5. The school nurse and cafeteria manager will be notified upon processing.

6. To better serve our students, the parent/legal guardian is responsible for completing a new form whenever changes occur (including switching to a different school within the district during the school year, returning to the district, medical or health changes, etc.)

7. HEB will provide menu and nutrition information on the department's website for parents with children that have special dietary needs.

*** It is the responsibility of the parent to review the menu and communicate to their child regarding what food choices they can and cannot have daily. A copy of the menu is available online at www.hebisd.edu. ***

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Student's Name: _____ ID #: _____
LAST NAME FIRST NAME MIDDLE INITIAL

School: _____ Grade: _____ Date of Birth: _____

*** To Be Completed Only by Physicians, Physician Assistants or Advanced Practice Nurses ***

Does the student have a disability or a food allergy that results in severe, life threatening (anaphylactic) reaction? (please circle yes or no)	**Yes**	**No**

If Yes,

1. List the disability or food allergy that causes anaphylaxis: _____
2. Explain why the disability restricts the child's diet: _____
   _____
3. Describe the major life activities affected by the disability: _____
   _____
4. If any, list foods to be omitted and the foods to be substituted below:

Omit: _____	Omit: _____
Complete one of the following:	Complete one of the following:
☐ Substitute with menu items that do not contain known allergen or food listed above.	☐ Substitute with menu items that do not contain known allergen or food listed above.
OR	**OR**
☐ Substitute only _____ for the known allergen or food listed above.	☐ Substitute only _____ for the known allergen or food listed above.

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

Chopped/Bite Size Pieces: _____

Finely Ground: _____

Pureed: _____

List any special equipment or utensils that are needed.

Additional comments about the child's eating or feeding patterns:

_____ _____ _____
Name of Physician/Physician Assistant/Advanced Practice Nurse | Telephone Number | Fax Number

_____ _____
Signature of Physician/Physician Assistant/Advanced Practice Nurse | Date

I understand that it is my responsibility to submit a new form anytime changes occur (ie. child's medical or health needs changes, switching schools during school year, etc.).

_____ _____
Name of Parent/Legal Guardian | E-mail Address

_____ _____ _____
Signature of Parent/Legal Guardian | Telephone Number | Date

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 major life activities, has a record of such an impairment or is regarded as having such an impairment.Children with food allergies or intolerances do not have a disability as defined under either Section 504 of the Rehabilitation Act or Part B of IDEA. Child Nutrition (Food & Nutrition Services) may, but is not required to, make food substitutions for them.** - Texas Department of Agriculture, May 2005.The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

For HEBISD CNS Use Only: Date Received: ___ /___ /___ Comments: _____