DONNA INDEPENDENT SCHOOL DISTRICT

PHYSICIAN'S REQUEST FOR DIET MODIFICATIONS

Campus: _____
Teacher/Nurse: _____
School Year: _____

FORM #1

THIS SECTION MUST BE COMPLETED BY *PARENT/GUARDIAN*

Student Name: DOB: Student ID#: Grade:	Parent/Guardian: Parent/Guardian Contact Number: Parent/Guardian Contact Email:

As a parent/guardian, I give permission for Donna ISD to contact the physician's office regarding my child's dietary needs.
□ **Yes** □ **No**

_____ _____
Parent/Guardian Signature **Date**

Which meals will the student eat from the school cafeteria (check all that apply)? □ Breakfast □ Lunch □ Supper

MEDICAL DIAGNOSIS

REQUIRED* THIS SECTION MUST BE COMPLETED BY A *LICENSED PHYSICIAN OR AUTHORIZED MEDICAL PROFESSIONAL

1. Does student have a Disability or severe food allergy that is **life-threatening/anaphylactic** (must be answered)? *Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, define a person with disability as any person who has a physical or mental impairment which substantially limits one or more "major life activities," has a record of such impairment, or is regarded as having such impairment."*

□ **YES**, continue with Section **A**
□ **NO**, please complete **Section B**

2. Does the student have an Epi-pen prescription for food allergy: □ **YES** □ **NO**

3. Please check the medical diagnosis requiring meal modification/substitution:
□ Type I/II Diabetes Mellitus □ PKU □ Celiac Disease □ Gastritis/Digestive (specify) _____ □ Other: _____

4. Please describe the major life activities affected by the disability: _____

SECTION A
Disability or Severe Life Threatening Food Allergy

Milk
□ No fluid dairy Milk
□ No milk/milk products, even as ingredient in cooked or processed foods □ May substitute fluid milk with soy milk
□**N/A**

Soy
□ Avoid Soy Protein Only
□ Avoid soy protein and derivatives (i.e. soybean oil/soy lecithin)
□**N/A**

Fish
□ Fish □ Shellfish □ Other: _____ □**N/A**

Eggs
□ No eggs, fresh and liquid
□ No eggs, even as ingredient in cooked or processed foods
□**N/A**

Nuts
□ Peanuts □ Tree Nuts □ Other: _____ □**N/A**

NOTES:

OR

SECTION B
Non-Life Threatening Allergy/Intolerance

Milk/Dairy: □ **Allergy** □**N/A**
□ No fluid milk □ No yogurt □ No cheese
□ No milk/milk products, even as ingredient in cooked or processed foods □ May substitute soy milk in place of dairy milk

Lactose Intolerance
□ No fluid milk □ No yogurt □ No cheese
□ May provide lactose-free milk

Soy: □ **Allergy** □ **Intolerance** □**N/A**
□ Avoid Soy Protein Only
□ Avoid soy protein and soy derivatives (i.e. soybean oil/soy lecithin)

Fish: □ **Allergy** □ **Intolerance** □**N/A**
□ Fish □ Shellfish □ Other: _____

Eggs: □ **Allergy** □ **Intolerance** □**N/A**
□ No eggs, fresh and liquid
□ No eggs, even as ingredient in cooked or processed foods

Nuts: □ **Allergy** □ **Intolerance** □**N/A**
□ Peanuts □ Tree Nuts □ Other: _____

NOTES:

Other (not listed)
□ **Allergy** □ **Intolerance** □ **Other** _____

Please check **ALL** that apply and **N/A** to the ones that do not apply to student.

RESTRICTIONS AND LIMITATIONS (must be filled out)

List foods to omit and/or substitutions:

Please specify reactions or limitations student may experience with these foods:

TEXTURE MODIFICATIONS

Does student need texture modifications (Check one): □ **YES** □ **NO**

If so, are they needed □ **Year-Round** or □ **Temporary**: Start _____ to_____

Solids: □ Pureed (Level 1) □ Mechanical Soft/Ground (Level 2) □ Other: _____

Liquids: □ Nectar Thick (Mild) □ Honey Thick (Moderate) □ Spoon Thick (Extreme)

_____

Physician's Signature

Physician's Full Name, Print: _____ **Date:** _____

□ **MD** □ **DO** □ **PA** □ **NP**

Office/Contact Number:

Please fill out form in its entirety. Check off N/A if it DOES NOT apply to student.

NOTE: After correctly completing this form and form is **accepted** by CNP Staff, a minimum of ***7 days*** is needed to accommodate special diet.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

All completed forms may be returned to the School Nurse. Nurse will send to CNP Dietitian email reyes.banda@donnaisd.net