GALENA PARK I.S.D.
CHILDCARE CENTER

South Campus ◊ 1906 2nd St. Galena Park, TX 77547
Phone 832·386·3760 ◊ Fax 832·386·2013

North Campus ◊ 325 Barbara Mae, Houston, TX 77015
Phone 832-386-2090 ◊ Fax 832-386-2091

Diaper Cream/Ointment Authorization Form

Child's Name:	Date of Birth:
Name of Medication/Cream to be applied: (Check all that apply.) ☐ Any over-the-counter diaper cream ☐ Only specific brand(s) allowed: _____ ☐ Prescription cream: _____	
Times to be applied: ☐ When rash is present ☐ With every diaper change ☐ Other:	**Amount to be applied:**
Special Instructions:	

Reason for medication: For diaper rash prevention or treatment
Route: Topical
Storage: Room temperature

I authorize the use of the above diaper cream/ointment on my child.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Health Care Provider Signature **Date**

_____ _____
Health Care Provider Printed **Date**

_____
Health Care Provider Phone Number

Physician's Request For Non-Standard Formula & Infant Food

THIS SECTION IS TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Student Name: _____ **Date of Birth:** _____

School Name: _____ **Student ID:** _____

Parent/Guardian Name: _____ **Phone:** _____

As parent or guardian, I give permission for Galena Park ISD to contact the physician's office regarding my child's dietary needs.

Parent Signature: _____ **Date:** _____

THIS SECTION IS TO BE COMPLETED BY LICENSED PHYSICIAN

The US Department of Agriculture School Meals Program requires that **ALL** questions be answered in order for ANY diet modification or substitution to be made

Does the child have a disability and/or life-threatening food allergy requiring diet modification? Yes ☐ No ☐

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".

If YES, please describe the major life activities affected: _____

**If the student does NOT have a disability and/or food allergy, this form does not need to be completed and will be disregarded*

Medical Diagnosis: _____

Qualifying Conditions: *(Please check all that applies)*

All changes or updates to diet modifications must be provided in writing by a Licensed Physician

- ☐ Cardiovascular condition
- ☐ Developmental delays
- ☐ Seizure disorder
- ☐ Respiratory condition
- ☐ Oral motor feeding issues
- ☐ Tube feeding
- ☐ FTT
- ☐ GI disorder
- ☐ Inadequate growth
- ☐ Prematurity/LBW
- ☐ Malabsorption/Maldigestion
- ☐ GER/GERD
- ☐ Renal disorder
- ☐ Food allergies (cow's milk, soy, or intact protein)/FPIES
- ☐ Other: _____

Formula Options:

- ☐ Similac Soy Isomil *(soy-based)*
- ☐ Enfamil Gentlease *(for mild lactose intolerance)*
- ☐ Enfamil A.R *(for mild lactose intolerance)*
- ☐ Enfamil Reguline *(for mild lactose intolerance)*
- ☐ Other: _____

Infant Food: *(If applicable)* Check Foods to **remove** from the menu

- ☐ Infant cereal
- ☐ Baby food* *(due to delay or inability to consume solids)*
- ☐ Formula only, no foods *(due to delay or inability to consume solids)*

*Please specify food item to omit: _____

I, _____, physician for _____, declare the herein mentioned child Physician's Name Child's Name to possess the following listed Life Threatening Food Allergies and/or Disabilities. Alternate foods should be offered at school in accordance with the following guidelines.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Clinic Name: _____ **Clinic Address:** _____

Send the completed form to the school nurse and forward a copy to tvo@galenaparkisd.com.
Please allow two business weeks for processing.

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 a program discrimination complaint, a Complainant should complete 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-Form0508-0002-508-11-28-17Fax2Mail.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:

1. 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.

Physician's Request For Special Dietary Accommodations

THIS SECTION IS TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Student Name: _____ **Date of Birth:** _____

School Name: _____ **Student ID:** _____

Parent/Guardian Name: _____ **Phone:** _____

Parent's Email: _____

Which meals will the student be eating from the school cafeteria?

Breakfast ☐ **Lunch** ☐ **Supper** ☐

As parent or guardian, I give permission for Galena Park ISD to contact the physician's office regarding my child's dietary needs.

Parent Signature: _____ **Date:** _____

THIS SECTION IS TO BE COMPLETED BY LICENSED PHYSICIAN

The US Department of Agriculture School Meals Program requires that **ALL** questions be answered in order for ANY diet modification or substitution to be made

Does the child have a disability and/or life-threatening food allergy requiring diet modification? Yes ☐ No ☐

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".

If YES, please describe the major life activities affected: _____

**If the student does NOT have a disability and/or food allergy, this form does not need to be completed and will be disregarded*

Does the student have a prescription for an Epi-pen for a food allergy? Yes ☐ No ☐

Medical Diagnosis: _____

Food to be omitted: *All changes or updates to diet modifications must be provided in writing by a Licensed Physician*

☐ Peanuts ☐ Tree Nuts ☐ Fish/Seafood ☐ Shellfish ☐ Eggs by themselves ☐ Eggs as an ingredient

☐ Soy as main ingredient ☐ All food containing soy ☐ Wheat/Gluten ☐ Fluid Milk

☐ Dairy products (cheese, yogurt, etc.) ☐ Other: _____

Substitutions: _____

Other accommodations needed:

Texture Modification:

Solids:
- ☐ Soft & Bite-Sized (Level 6)
- ☐ Minced & Moist (Level 5)
- ☐ Pureed (Level 4)
- ☐ None

Liquids:
- ☐ Extremely Thick (Level 4)
- ☐ Moderately Thick (Level 3)
- ☐ Mildly Thick (Level 2)
- ☐ Slightly Thick (Level 1)
- ☐ None

Supplements (*if any*): _____

I, _____, physician for _____, declare the herein mentioned child Physician's Name Child's Name to possess the following listed Life Threatening Food Allergies and/or Disabilities. Alternate foods should be offered at school in accordance with the following guidelines.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Clinic Name: _____ **Clinic Address:** _____

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