



# Fredericksburg ISD

## Request for Dietary Accommodation

Instructions: Part A: Parent/Guardian completes

Part B: Physician completes

Part C: School Nurse completes. Nurse to keep a copy

Scan and e-mail to Kelsey Kerr, Director of School Nutrition, kelseyk@fisd.org

Parent/Guardian and School Nurse will be notified after request is evaluated.

Instrucciones: Padre o Tutor completa PARTE A.

El Médico completa PARTE B.

Enfermera Escolar completa PARTE C.

Escanee y envíe un correo electrónico a Kelsey Kerr, Directora de Nutrición Escolar, kelseyk@fisd.org

Padre o Tutor y Enfermera de la escuela serán notificados después de evaluar la solicitud.

| Parent/Guardian PART A                                                                                                                                                                                                                                      |                                                  |             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------|
| Student's Name:                                                                                                                                                                                                                                             | Age:                                             | Student ID: |
| School:                                                                                                                                                                                                                                                     | Grade:                                           | Classroom:  |
| Printed Parent or Guardian's Name:                                                                                                                                                                                                                          | E-mail:                                          | Phone:      |
| PART B                                                                                                                                                                                                                                                      |                                                  |             |
| <b>Physician licensed to practice medicine in the state of Texas is required to complete PART B and sign.</b>                                                                                                                                               |                                                  |             |
| 1. Does the Child have a disability recognized by the American's with Disability Act (ADA)?                                                                                                                                                                 | YES                                              | NO          |
| If No, skip to Question # 3                                                                                                                                                                                                                                 |                                                  |             |
| 2. If YES, please identify the disability and describe the major life activities affected by the disability.                                                                                                                                                |                                                  |             |
| 3. If the Child does not have a disability, does the child have a food allergy or intolerance that results in an anaphylactic reaction when exposed to the food (s) to which they have problems?                                                            | YES                                              | NO          |
| 4. If the answer to Questions 1 or 3 is YES, please check the following that affect the child.<br>Dairy ____ Egg ____ Egg White ____ Gluten ____ Nut(s) ____ Soy ____ PKU ____<br>Other: _____<br>Any additional information:                               |                                                  |             |
| 5. For food texture modification. List the foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "all"<br>(a) Cut up or chopped into bite size pieces.<br>(b) Finely ground.<br>(c) Pureed or Blended. |                                                  |             |
| 6. Indicate any other comments about the child's eating or feeding patterns.                                                                                                                                                                                |                                                  |             |
| Licensed physician's printed or stamped name                                                                                                                                                                                                                | Office Phone: _____<br>Office Fax /Email : _____ |             |
| Licensed physician's signature                                                                                                                                                                                                                              |                                                  |             |
| Date: _____                                                                                                                                                                                                                                                 |                                                  |             |
| School Nurse: PART C                                                                                                                                                                                                                                        |                                                  |             |
| 7. Does the Child have "Individualized Health Care Plan" (IHCP).                                                                                                                                                                                            | YES                                              | NO          |
| 8. Does the Child have a 504 Plan?                                                                                                                                                                                                                          | YES                                              | NO          |