CHILD NUTRITION SERVICES DEPARTMENT

Physician's Request for Special Dietary Accommodations

Date: _____
School Year: _____

All sections must be completely filled out for this form to be accepted. * Indicates a required field

A. THIS SECTION TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

*Student Last name: _____ *First Name: _____ Date of Birth: ___ / ___ / ____

*School: _____ Grade: _____ Student ID: _____

Parent / Guardian Name: _____ Phone: _____

School Nurse: _____ Phone: _____

I give Health Services/Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

Parent Signature: _____ Date: _____

B. THIS SECTION TO BE COMPLETED BY PARENT / LEGAL GUARDIAN ** REQUESTS OF THIS TYPE MUST BE SUBMITTED ANNUALLY TO THE SCHOOL NURSE

☐ I am requesting a fluid milk substitution based on my child's special dietary need.

Explain circumstances involving the special dietary need: _____

☐ I am requesting meal accommodations due to my child's religious or cultural practices.

Explain circumstances involving the meal accommodation needed: _____

C. THIS SECTION TO BE COMPLETED BY A PRESCRIBING MEDICAL AUTHORITY OR REGISTERED DIETITIAN.

*** Does the child have a disability and/or anaphylactic/life-threatening food allergy?** ☐ YES ☐ NO *If YES selected, form must be completed and signed by a medical authority or registered dietitian.*

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

*** MEDICAL DIAGNOSIS:** _____

ACCOMMODATIONS NEEDED

I. Restrictions Needed: ☐ **NONE**

^ Lactose Free milk is the standard substitution when Fluid Dairy Milk is omitted

- ☐ No Fluid Dairy Milk ^
- ☐ No Dairy Products (yogurt, cheese, etc)
- ☐ No Milk Protein / Milk Ingredients (in baked goods, etc.)
- ☐ No Whole Eggs
- ☐ No Eggs as an ingredient
- ☐ No Wheat/Gluten
- ☐ No Soy Ingredients
- ☐ No Sesame
- ☐ No Peanuts
- ☐ No Tree Nuts
- ☐ No Whole Corn
- ☐ No foods processed in a facility that contains nuts
- ☐ No Corn Derivatives
- ☐ No Fish
- ☐ No Seafood
- ☐ Other (please list): _____

Substitutions: _____

II. Texture Modification: ☐ **NONE**

If texture modifications are needed, a meeting involving the parent / guardian, nurse, and nutrition services will be required.

Duration: (choose one)
- ☐ Year Round
- ☐ Temporary: Start _____ Stop _____

Liquids: (choose one)
- ☐ Mildly Thick (level 2)
- ☐ Moderately Thick (level 3)
- ☐ Extremely Thick (Level 4)

Solids: (choose one)
- ☐ Soft & Bite-Sized (level 6)
- ☐ Minced & Moist (level 5)
- ☐ Pureed (Level 4)

D. THIS SECTION TO BE COMPLETED BY A PRESCRIBING MEDICAL AUTHORITY OR REGISTERED DIETITIAN.

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.

***Signature of Licensed Physician/Prescribing Medical Authority or Registered Dietitian** **Date**

***Printed Name of Licensed Physician/Prescribing Medical Authority or Registered Dietitian**

Phone Fax

Address

Send completed form to school nurse. *Please submit a new Physician Request form each school year. Any change or discontinuation must be submitted in writing. Please allow two business weeks for processing. Contact CNS@wacoisd.org with questions.*