



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

Liquids: (choose one)

Solids: (choose one)

- | | | |
|--|---|--|
| ☐ Year Round | ☐ Mildly Thick (level 2) | ☐ Soft & Bite-Sized (level 6) |
| ☐ Temporary: Start ____ Stop ____ | ☐ Moderately Thick (level 3) | ☐ Minced & Moist (level 5) |
| | ☐ Extremely Thick (Level 4) | ☐ 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.

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, 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 a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.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.