

Student's Name		Age
Name of School	Grade Level	Classroom

Pflugerville Independent School District
SPECIAL MEALS REQUEST FORM
Eating and Feeding Evaluation

The Child Nutrition Department is required by the United States Department of Agriculture (USDA) to provide appropriate menu substitutions to students with life-threatening allergies (those that can cause anaphylactic reactions), or for students with disabilities that restrict their diet.

If this is a life-threatening allergy, or if your child has a disability that restricts their diet, please supply your school cafeteria manager with this SPECIAL MEALS REQUEST FORM (Parts A & B), completed in full and signed by a licensed physician.

If you child's food allergy is NOT life-threatening, the Child Nutrition Department may, although is not required, to make the requested menu substitutions. Decisions will be made on a case-by-case basis. Food substitutions may be made at the discretion of the Child Nutrition Department for individual students who do not have a disability or life-threatening allergy, but who are medically certified as having a special dietary need, or religious diet request. Before any decisions are made, this SPECIAL MEALS REQUEST FORM (Parts A & C) must be completed in full and signed by a recognized medical authority where requested. If you have questions or concerns, please feel free to contact the Child Nutrition Department's Director, Geoff Holle (Geoff.Holle@pfisd.net; 512-594-0432) or Registered Dietitian, Kristin Joe at kristin.joe@pfisd.net; 512-594-0438).

PISD's Child Nutrition Department does provide non-dairy or lactose-reduced/lactose-free milk substitutes to non-disabled students who cannot drink fluid milk due to a medical or special dietary need. Additionally, juice is not an approved fluid milk substitute, unless clearly stated by a physician in relation to a student with a life-threatening allergy or disability. Milk is not required to be taken as part of Offer-vs-Serve regulations and students may choose juice when offered as a fruit component in the meal. If you would like to request an alternative fluid milk substitute, per USDA guidelines, please complete this SPECIAL MEALS REQUEST form(parts A & D, in full).

PART A.

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modifications or substitutions to be made to school meals.

TO BE COMPLETED BY PARENT OR GUARDIAN

☐ My child will be eating school prepared meals. Please define frequency and meals the student will participate in...

☐ My child will not be eating school-prepared meals.

I understand that it is my responsibility to renew this form before each school year and anytime my child's medical or health needs change. As the parent or guardian, I give permission for Pflugerville ISD to contact the physician's office regarding my child's dietary needs.

Parent/Guardian Printed Name	Parent/Guardian Signature	Contact Number(s)

For students with life-threatening allergies or disabilities, continue to PART B (TO BE COMPLETED BY PHYSICIAN'S OFFICE).

For students who do not have a disability or life-threatening allergy, but who are medically certified as having a special dietary need, or religious preference, continue to PART C (TO BE COMPLETED BY A RECOGNIZED MEDICAL AUTHORITY or PARENT/GUARDIAN FOR RELIGIOUS REQUEST).

Pflugerville ISD is not responsible for and cannot guarantee the accuracy of any child's diet. Products stocked by Pflugerville ISD can change due to supplier changes or substitutions or manufacturer's formulation changes. Cafeteria managers and staff are not trained in dietary modifications. Parents are welcome to look at any food ingredient labels or recipes.

For students requesting a fluid milk substitute, continue to PART D

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PART B.

For Students with Disabilities and Life-Threatening (Anaphylaxis) Allergies

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modifications or substitutions to be made to school meals.

TO BE COMPLETED BY PHYSICIAN'S OFFICE

SECTION 1.

- A) Does the Child have a Disability or a life-threatening allergy* ?

Yes ☐

No ☐

If no, continue to PART C.

**Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment or is regarded as having such an impairment.*

- B) The child listed above possesses the following disability or life-threatening allergy: _____

- C) Explanation of why this disability restricts diet.

- D) Major Life Activities affected by the disability/life-threatening allergy (check all that apply):

- | | | | | |
|--|-----------------------------------|------------------------------------|--|----------------------------------|
| ☐ Caring for one's self | ☐ Eating | ☐ Walking | ☐ Seeing | ☐ Hearing |
| ☐ Learning | ☐ Speaking | ☐ Breathing | ☐ Performing Manual Tasks | |

- E) Does the child with the disability have special nutrition or feeding needs?

If Yes, continue to SECTION 2. and have this form signed by a licensed physician.

Yes ☐

No ☐

SECTION 2.

- A) Foods/Beverages to omit: _____

- B) Foods/Beverages to substitute with: _____

- C) Can the student consume foods where the allergen(s) is an ingredient in the food product (for example, eggs are omitted, but eggs as an ingredient in pancakes is allowed?). _____

- D) If allergic to soy, are the following ingredients allowable? Soybean oil (Y / N) Soy Lecithin (Y / N)

- E) If allergic to corn, are the following ingredients allowable? Corn Starch (Y / N) Corn Syrup (Y / N)

- F) Texture Modification, if applicable:

- | | | | |
|----------------|---|---------------|---|
| Liquids | ☐ Thin | Solids | ☐ Soft and Bite-Sized; "Chopped" (IDDSI 6) |
| | ☐ Mildly Thick; "Nectar" (IDDSI 2) | | ☐ Minced and Moist; "Ground" (IDDSI 5) |
| | ☐ Moderately Thick; "Honey" (IDDSI 3) | | ☐ Pureed (IDDSI 4) |
| | ☐ Extremely Thick; "Pudding" (IDDSI 4) | | ☐ Check here if only for religious exemption |

Please provide additional comments or information as related to diet and/or feeding techniques.

_____ Printed Physician's name	_____ Physician's Signature	_____ Date
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_____ Clinic/Facility Name	_____ Phone Number	_____ Fax Number
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PART C.

For Students without disabilities but with special dietary needs requiring food substitutions or modifications.

Food substitutions or modifications for students with intolerances and allergies; or religious meal modification requests, may be requested on this form, however, the Child Nutrition Department is not required to provide substitutions to students without disabilities or life-threatening (anaphylaxis) allergies. Such determinations are only made on a case-by-case basis.

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modifications or substitutions to be made to school meals.

This form must be completed in full and signed by a Recognized Medical Authority (Physician, Physician's Assistant or Advance Nurse Practitioner). For religious meal modification requests, completed form with only Parent or Guardian signature and contact information required.

TO BE COMPLETED BY RECOGNIZED MEDICAL AUTHORITY

(Physician, Physician's Assistant or Advanced Nurse Practitioner Unless Religious Request)

A) Name & describe the food intolerance, allergy or special dietary need:

B) Describe the medical or other special dietary reason for the need for substitution:

C) Foods/Beverages to omit (please be specific):

D) Foods/Beverages to substitute with (please be specific):

E) Can the student consume foods where the allergen is an ingredient in the food product (for example, eggs are omitted, but eggs as an ingredient in pancakes is allowed?) _____

F) Texture Modification, if applicable:

Liquids	☐ Thin	Solids	☐ Soft and Bite-Sized; "Chopped" (IDDSI 6)
	☐ Slightly Thick; "Nectar" (IDDSI 2)		☐ Minced and Moist; "Ground" (IDDSI 5)
	☐ Moderately Thick; "Honey" (IDDSI 3)		☐ Pureed (IDDSI 4)
	☐ Extremely Thick; "Pudding" (IDDSI 4)		☐ Check here if only for religious exemption

Please provide additional comments or information as related to diet and/or feeding techniques.

Printed Name of Recognized
Medical Authority (Parent or
guardian if religious request ONLY)

Signature of Recognized Medical
Authority (Parent or guardian if
religion request ONLY)

Date

Clinic/Facility Name

Phone Number

Fax Number

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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 a 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-Form-0508-0002-508-11-28-17Fax2Mail.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:

mail:

1. 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

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PART D:
Fluid Milk Substitute Request Form

Disability- Based Fluid Milk Substitute Request:

TO BE COMPLETED BY A PARENT OR GUARDIAN, MEDICAL AUTHORITY, OR REGISTERED
DIETITIAN. A MEDICAL NOTE IS NOT REQUIRED.

- A) Please identify the disability (physical or mental impairment) that substantially limits one or more major life activities, including eating, digestion, or bodily functions, as defined under Section 504 and the ADA that requires a fluid milk substitute (e.g. lactose intolerance, milk allergy, or other):

- B) Please check the substitute requested:

- ☐ Soy Milk
☐ Lactose-free Milk
☐ Other (please specify): _____.

(Note: Disability-based substitutes do not need to be nutritionally equivalent to cow's milk and do not need to meet meal pattern requirements).

- C) Certification:

☐ Parent/Guardian ☐ Licensed Medical Professional

Printed Name of Parent/Guardian
Or Medical Authority

Signature

Date

Phone number

Fax Number (If applicable)

Discretionary Fluid Milk Substitute Request:

TO BE COMPLETED BY A PARENT OR GUARDIAN, MEDICAL AUTHORITY, OR REGISTERED
DIETITIAN. A MEDICAL NOTE IS NOT REQUIRED.

- A) Please describe the reason the student needs a milk substitute (e.g. religious reason, vegan, diet, or taste preference).

- B) Please check the substitute requested:

- ☐ Soy Milk
☐ Lactose-free Milk
☐ Other (please specify): _____.

(Note: Non-dairy substitutes for nondisability reasons must meet USDA nutritional requirements to be reimbursable as part of the meal).

- C) Certification

☐ Parent/Guardian ☐ Licensed Medical Professional

Printed Name of Parent/Guardian
Or Medical Authority

Signature

Date

Phone number

Fax Number (If applicable)

PfISD is not required to accommodate *discretionary* milk substitute requests. Decisions will be made on a case by case basis.