



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 a parent or guardian, I give permission for Galena Park ISD to contact the physician's office regarding my child's dietary needs. **I acknowledge that a la carte purchases are not monitored by the cafeteria for allergens. If I would like to prevent my child from buying a la carte items, I may set these restrictions on www.schoolcafe.com/galenaparkisd**

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: _____

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

Medical Diagnosis: _____

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

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 ☐ Wheat/Gluten ☐ Sesame
- ☐ **Egg allergy (specify):** ☐ Omit only whole Plain Eggs (ex, scrambled eggs) ☐ Omit all eggs (i.e. eggs in baked goods)
- ☐ **Dairy allergy (specify):** ☐ Omit only fluid milk ☐ Omit cheese ☐ Omit yogurt ☐ Omit all dairy including trace amount
- ☐ **Soy allergy (specify):** ☐ Omit soy as main ingredient (soy milk, edamame, soy sauce) ☐ Omit all food containing soy
- ☐ Other: _____

Substitutions: _____

Texture Modification:

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

Liquids: ☐ Extremely Thick (Level 4) ☐ Moderately Thick (Level 3) ☐ Mildly Thick (Level 2) ☐ Slightly Thick (Level 1)

Oral 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: _____

Send the completed form to the school nurse and forward a copy to tvo@galenaparkisd.com.

Please allow two (2) 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, 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.



Physician's Request For Special Dietary Accommodations / Solicitud del médico para adaptaciones dietéticas especiales

THIS SECTION IS TO BE COMPLETED BY PARENT/LEGAL GUARDIAN / ESTA SECCIÓN DEBE SER LLENADA POR EL PADRE/TUTOR LEGAL

Nombre del estudiante: _____ Fecha de nacimiento: _____
Nombre de la escuela: _____ # de ID del estudiante: _____
Nombre del Padre/Tutor: _____ Teléfono: _____
Correo electrónico del Padre/Tutor: _____

¿Qué comidas comerá el estudiante de la cafetería de la escuela? Desayuno ☐ Almuerzo ☐ Cena ☐

Como padre o tutor, doy permiso a Galena Park ISD de contactar la oficina del médico en relación a las necesidades dietéticas de mi hijo/a. **Reconozco que la cafetería no controla los alérgenos en las compras para el menú a la carta. Si quiero evitar que mi hijo/a compre artículos del menú a la carta, puedo establecer estas restricciones en www.schoolcafe.com/galenaparkisd**

Firma del Padre/Tutor: _____ Fecha: _____

THIS SECTION IS TO BE COMPLETED BY LICENSED PHYSICIAN / ESTA SECCIÓN DEBE SER LLENADA POR UN MÉDICO CERTIFICADO

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Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Clinic Name: _____ Clinic Address: _____

Parent / Padre de familia: Envíe el formulario completo a la enfermera de la escuela y también envíe una copia a tvo@galenaparkisd.com.

Por favor espere dos (2) semanas hábiles para que se realice el proceso.

De acuerdo con la ley federal de derechos civiles y las normas y políticas de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA, por sus siglas en inglés), esta institución tiene prohibido discriminar por motivos de raza, color, nacionalidad, sexo, discapacidad, edad, o tomar represalias por actividades previas en materia de derechos civiles. La información del programa puede estar disponible en otros idiomas. Las personas con discapacidad que necesiten medios de comunicación alternativos para obtener información del programa (por ejemplo, braille, letra grande, audio, lenguaje de señas americano) deben comunicarse con la agencia estatal o local responsable que administra el programa o con el Centro TARGET del USDA al (202) 720-2600 (voz y TTY) o al USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en el programa, el denunciante debe completar el Formulario AD-3027, Formulario de Queja por Discriminación en el Programa del USDA, que puede obtenerse en línea en: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, en cualquier oficina del USDA, llamando al (866) 632-9992 o escribiendo una carta dirigida al USDA. La carta debe incluir el nombre, la dirección y el número de teléfono del denunciante, así como una descripción por escrito de la presunta acción discriminatoria con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR, por sus siglas en inglés) sobre la naturaleza y la fecha de la presunta violación de derechos civiles.

El formulario o carta AD-3027 completa debe enviarse al USDA por:

1. correo postal: Oficina del Subsecretario de Derechos Civiles del Departamento de Agricultura de EE. UU. 1400 Independence Avenue, SW Washington, D.C. 20250-9410; o

2. fax: (833) 256-1665 o (202) 690-7442; o

3. correo electrónico: program.intake@usda.gov

Esta institución es un proveedor de igualdad de oportunidades.