

Physician's Request for Dietary Accommodations

All sections must be **completely** filled out for this form to be accepted. A. THIS SECTION TO BE COMPLETED BY PARENT/ LEGAL GUARDIAN Student Name: _____ Date of Birth: ___/___ Student ID: School Year: _____ _____ Grade: _____ Campus: Phone: _____ Parent/Guardian Name (please print): Email Address: _____ Signature: Date: ______(Parent/Guardian) of _______(Student) do not wish to participate in I/We, the Food Allergy program. I/We release Lamar Consolidated Independent School District, including its officers and employees, from any liability arising from their negligent acts or omissions that are in any way related to my student's food allergy. B. THIS SECTION TO BE COMPLETED BY LICENCED PHYSICIAN Does the child have a disability? 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 life activities, has a record of such an impairment or is regarded as having such an impairment. If yes, please describe the major life activities affected by the disability: Medical Diagnosis: **Check Foods to be Omitted:** _____ Peanuts _____ Tree Nuts _____ Soy _____ All Soy Protein (oil, lecithin, etc.) _____ Fish ____ Shellfish ____ Fluid Milk ____ Fluid Milk & Dairy ____ All Milk Protein (casein, whey, etc.) ____ Egg ____ Wheat Other (please be specific): _____ Can the student consume foods when the allergen is an ingredient in the food product? Yes (example: scrambled eggs are omitted however egg as an ingredient in pancakes is allowed) Explain: **Texture Modification** List foods that need the following texture modification. If all foods need to be prepared in this manner, indicate "ALL". Pureed: Finely chopped: Bite size pieces: Other (please be specific): Clinic/ Facility Name: ______ Telephone: ______ Address: Physician Name (please print): ______

Send completed form to school nurse. Physician request forms **MUST** be renewed each school year. Any change or discontinuation must be submitted in writing by the physician. The Food Services Department may make food substitutions, at their discretion, for individual students who do not have a disability but who are medically certified as having a special medical or dietary need.

Physician Signature: ____

For questions about this form please contact LCISD Food Services Dietitian: Kasandra Davis, RD, LD. Phone: 832-223-0188, Fax 832-223-0187 or email kdavis02@lcisd.org

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completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C.; 20250-9410, by fax (202) 690-7442 or emit at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact

18150 Individuals be federal Relay Service of (800) 847-8339; or (800) 847-6339; or (800) 847-6339;