LAMAR CISD
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LCISD
Child Nutrition Department

Physician's Request for Dietary Accommodations

All sections must be **completely** filled out for this form to be accepted. **School Year:** _____

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

Student Name (Last, First): _____ **Date of Birth:** ____/____/_____

Campus:_____ **Grade:** _____ **Student ID:** _____

Which meals will the child consume at school? (please circle) Breakfast Lunch Will bring meals from home

Parent/Guardian Name (please print)**:** _____ **Phone:** _____

Email Address: _____

I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the school nurse and the dietitian.

Signature: _____ **Date:** _____

B. PARENT / LEGAL GUARDIAN CAN DECLINE ACCOMMODATIONS BELOW

I/We, _____(Parent/Guardian) of _____(Student) ***DO NOT*** *wish to participate in the Dietary Accommodation program.*

Signature: _____ **Date:** _____

C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN

Does the child have a disability or anaphylactic/ life threatening food allergy? Yes No

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 (REQUIRED): _____

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/ Gluten

____ Other (please be specific): _____

Can the student consume foods when the allergen is an ingredient in the food product? Yes No

(example: whole eggs and scrambled eggs are omitted however egg as an ingredient in pancakes and waffles are allowed)

Explain: _____

Texture Modification

List foods that need the following texture modification. If all foods need to be prepared in this manner, indicate "ALL".

Bite size pieces: Finely chopped: Pureed:

Other (please be specific): _____

Clinic/ Facility Name: _____ Phone: _____

Address: _____

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.

Physician Name (please print): _____ **Date:** _____

Physician Signature: _____

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 Child Nutrition 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.*

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