Education • Nutrition • Performance
HISD FOOD SERVICES
working in partnership with ARAMARK

Physician's Request for Special Dietary Accommodations

All sections must be completely filled out before form will be accepted.

Date: _____

Part I

Name of Students (Last): _____ (First): _____ Date of Birth: ___/___/____

School Attended: _____ Grade:_____ Student ID#:_____

Which meals will the child eat at school (please circle)? Breakfast Lunch After School Snack

School Nurse/ Nurse Consultant: _____ Contact Information: _____

Parent/Guardian: _____ Phone Number: _____ Email: _____

I give Health Services/ Food Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

_____
Parent/Guardian Signature Date

Part II

Does the child have a disability? 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: _____

Does the child have a life-threatening food allergy? Yes No

If yes to any of the above questions, Part III must be completed and signed by a Licensed Physician.
If no to both questions, Part III may be completed and signed by a Licensed Physician or Recognized Medical Authority.

Part III

Medical Condition: _____

Foods to be omitted:

____ Fluid Milk ____ All dairy products ____ All milk protein (casein, whey, etc.) ____ Soy protein
____ Wheat ____ Gluten ____ Eggs ____ All egg protein (albumin, etc.)
____ Seafood ____ Corn (as major ingredient) ____ All corn additives (dextrin, caramel color, etc.)
____ Peanuts ____ All Nuts ____ All foods produced in a facility with nut containing products
____ Other (please be specific): _____

Foods to be substituted: _____
(For non-disabled students who cannot have fluid milk, food services will choose the most appropriate milk substitute.)

Texture Modification: ____ soft ____ minced ____ pureed other (specify) _____

Supplement (circle one):
Boost Kid Essentials 1.0 Nutren Jr. Nutren Jr. with Fiber Peptamin Jr. 1.5
Peptamin 1.5 Nutren 1.5 *Other: _____
*Food Services will use brand equivalent unless box is checked ☐

Supplement dosage per meal:
_____ Breakfast _____ Lunch _____ After School Snack Program (if offered)

Will the student eat a regular meal along with receiving a supplement? Yes No

Name of Medical Authority (please print): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Mailing Address: _____

Send completed forms to school nurse/nurse consultant. **Physician requests must be renewed each school year. Any change of treatment must be requested in writing by the physician.** To ensure that the request is processed prior to the first day of school, submit the request no later than one month prior to the first day of school.