

Physician's Request for Special Dietary Accommodations

Date: _____

School Year: _____

All sections must be completely filled out for this form to be accepted. *indicates required field.

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

*Student Last Name: _____ *First Name: _____ Date of Birth: ___/___/___

School: _____ Grade: _____ Student ID: _____

Parent/Guardian Name: _____ Phone: _____

School Nurse: _____ Phone: _____

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

Parent Signature: _____ Date: _____

B. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

*Does the child have a disability and/or anaphylactic/life-threatening food allergy? YES NO *If YES selected, form must be completed and signed by licensed physician.*

*If YES, please describe the major life activities affected by the disability: _____

***MEDICAL DIAGNOSIS:** _____

ACCOMMODATIONS NEEDED

^Soy milk is the standard substitution when Fluid Dairy Milk is omitted

I. Restrictions Needed: NONE

No Fluid Dairy Milk^ No Dairy Products (yogurt, cheese, etc) No Milk Protein/Milk Ingredients (in baked goods, etc.)

No Whole Eggs No Eggs as an ingredient

No Wheat/Gluten No Soy ingredients

No Peanuts No Tree Nuts *(please note that HISD does not serve peanuts or tree nuts on the regular menus)*

No foods processed in a facility that contains nuts

No Seafood

Other (Please list) _____

Substitutions _____

II. Texture Modification: NONE

Duration: *(choose one)* Liquids: *(choose one)* Solids: *(choose one)*

Year-Round Mildly Thick (Level 2) Soft & Bite-Sized (Level 6)

Temporary: Start _____ Stop _____ Moderately Thick (Level 3) Minced & Moist (Level 5)

Extremely Thick (Level 4) Pureed (Level 4)

III. Supplement: NONE

NPO Supplement to accompany oral diet

Boost Kid Essentials 1.5 Pediasure Pediasure with Fiber Pediasure with Fiber 1.5 Pediasure Enteral with Fiber 1.0

Other: _____ **Supplements not listed above may take up to 6 weeks to be processed.*

Dosage Per Meal (REQUIRED): ___ Breakfast ___ Lunch ___ After School Snack

IV. Therapeutic Diet Order: Please provide specifics as needed. _____

C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

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.

_____ MD DO NP PA

*Signature of Licensed Physician/Prescribing Medical Authority Date

*Printed Name of Licensed Physician/Prescribing Medical Authority

Phone Fax

Address

Send completed form to school nurse. Please submit new Physician Request form each school year. Any change or discontinuation must be submitted in writing by the physician. Please allow two business weeks for processing. Fax completed forms to (713) 491-5998. Contact NSSPECIALDIETS@houstonisd.org with questions.

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Solicitud médica para realizarle modificaciones especiales a la dieta de un menor

Fecha: _____

No se aceptará el formulario si no se han llenado todas las secciones. El * indica dato requerido.

Ciclo escolar: _____

A. ESTA SECCIÓN DEBE LLENARLA EL PADRE O TUTOR

*Nombre del estudiante: _____ Fecha de Nac.: ___/___/___

Escuela: _____ Grado: _____ ID: _____

Padre o tutor: _____ Teléfono: _____

Enfermera de la escuela: _____ Teléfono: _____

Doj mi autorización para que los Servicios de Salud o los Servicios de Nutrición hablen con el doctor o la autoridad médica que se menciona más adelante para discutir las necesidades de alimentación que se describen a continuación:

Firma del padre o tutor: _____ Fecha: _____

B. ESTA SECCIÓN DEBE LLENARLA UN MÉDICO LICENCIADO O LA AUTORIDAD MÉDICA PERTINENTE

* ¿Tiene el niño una discapacidad o una alergia alimentaria que podría provocarle anafilaxis o poner en peligro su vida? SÍ NO *Si marcó SÍ, un médico licenciado debe llenar y firmar este formulario.*

* Si respondió SÍ, indique las actividades importantes afectadas por la discapacidad: _____

* **DIAGNÓSTICO MÉDICO:** _____

MODIFICACIONES NECESARIAS

[^]La leche de soya es la sustitución estándar cuando se omite la leche líquida de origen animal.

I. Restricciones necesarias: NINGUNA

- | | | |
|---|---|--|
| <input type="checkbox"/> No consumir leche de origen animal líquida [^] | <input type="checkbox"/> No consumir productos lácteos (yogur, queso, etc.) | <input type="checkbox"/> No consumir proteína láctea o ingredientes lácteos (en alimentos horneados, etc.) |
| <input type="checkbox"/> No consumir huevo entero | <input type="checkbox"/> No usar huevos como ingrediente | |
| <input type="checkbox"/> No consumir trigo o gluten | <input type="checkbox"/> No consumir soya | |
| <input type="checkbox"/> No consumir maní | <input type="checkbox"/> No consumir frutos secos (<i>Tenga presente que HISD no incluye maní o frutos secos en sus menús.</i>) | |
| <input type="checkbox"/> No consumir alimentos procesados en instalaciones donde haya habido nueces | | |
| <input type="checkbox"/> No consumir mariscos | | |
| <input type="checkbox"/> Otras (anote) _____ | | |

Alimentos sustitutos _____

II. Modificación de la textura: NINGUNA

Duración: (*marque una*)

- Durante todo el año
 Temporalmente: Iniciar _____ Terminar _____

Líquidos: (*marque una*)

- Levemente espeso (Nivel 2)
 Medianamente espeso (Nivel 3)
 Sumamente espeso (Nivel 4)

Sólidos: (*marque una*)

- Blando y tamaño de bocado (Nivel 6)
 Molido y húmedo (Nivel 5)
 Hecho puré (Nivel 4)

III. Suplementos: NINGUNA

- Nil per os (No ingerir nada por vía oral) Algún suplemento acompañará la dieta oral
 Boost Kid Essentials 1.5 Pediasure Pediasure con fibra Pediasure con fibra 1.5 Pediasure Enteral con fibra 1.0
 Otro: _____ **Podría tomar hasta 6 semanas incorporar suplementos que no se hayan indicado anteriormente.*

Dosis por alimento (ES REQUISITO): _____Desayuno _____Almuerzo _____Colación al término de las clases

IV. Orden de dieta terapéutica: Por favor ofrezca datos específicos: _____

C. ESTA SECCIÓN DEBE LLENARLA UN MÉDICO LICENCIADO O LA AUTORIDAD MÉDICA PERTINENTE

Yo certifico que el estudiante que se menciona arriba necesita las modificaciones dietéticas descritas, dado que presenta una discapacidad o una alergia alimentaria severa provocada por alimentos que ponen en riesgo su vida, como ya se ha mencionado.

MD DO NP PA

*Firma del doctor o autoridad médica _____ Fecha _____

*Nombre del doctor o autoridad médica _____

Teléfono _____ Fax _____ Domicilio _____

Entregue el forma lleno a la enfermera de la escuela. Deberá presentar uno nuevo cada año. Todo cambio o terminación de tratamiento debe comunicarse por escrito, de parte del médico. El trámite toma dos semanas. Mande la forma por fax a (713) 491-5998. Contacte NSSPECIALDIETS@houstonisd.org con preguntas.