HISD | Nutrition Services
IMPROVING LIVES. BUILDING TRUST.

Physician's Request for Special Dietary Accommodations

Date: _____

School Year: _____

Student's Name (Last, First) _____ **Date of Birth** _____

School _____ **Grade** _____ **ID**_____

Parent/Guardian _____ **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/Guardian Signature Date

Section A. ***(To be completed by a licensed physician)***
Disability or severe, life-threatening food allergy
Student's Medical Condition/Disability (**REQUIRED**) _____

_____

I. Disability or Severe Life-Threatening Food Allergy:
Student has allergies that are life threatening/anaphylactic?

☐ Yes, continue with this section ☐ No, refer to section B

☐ No Fluid Dairy Milk ☐ No Milk 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 Peanuts ☐ No Tree Nuts
☐ No foods processed in a facility that contains nuts
☐ No Seafood ☐ No Soy
☐ Other (Please list) _____

_____

Substitutions _____

II. Texture Modification:
☐ Year Round
☐Temporary: Start _____ Stop _____

Liquids:
☐ Thin (Regular Liquids)
☐ Nectar Thick
☐ Pudding Thick

Solids:
☐ Mechanical Soft (chopped)
☐ Mechanical Soft (ground)
☐ Pureed (Applesauce texture)

III. Supplement:
☐ NPO ☐ Supplement to accompany oral diet
☐ Boost Kid Essentials 1.0 ☐ Pediasure ☐ Pediasure w/ Fiber
☐ Pediasure w/ Fiber 1.5 ☐ Other: _____
Dosage Per Meal (**REQUIRED)**:

_____ Breakfast ____Lunch ____After School Snack
*Supplements not listed above may take up to 6 weeks to be processed.

IV. Therapeutic Diet Order: Please provide specifics below.

_____

_____

_____

Section B. ***(To be completed by a recognized medical authority)***
Food Allergy/Intolerance **(NOT LIFE THREATENING)**
Student without a disability but is requesting dietary accommodations
Please check one of the boxes below (REQUIRED):

☐ Allergy ☐ Intolerance ☐ Other_____

Student's allergy/intolerance to food(s) below:
DOES NOT result in a life-threatening/anaphylactic reaction*

☐ No Fluid Dairy Milk ☐ No Milk 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 Peanuts ☐ No Tree Nuts
☐ No foods processed in a facility that contains nuts
☐ No Seafood ☐ No Soy
☐ Other (Please list): _____

_____

_____

Substitutions _____

_____

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.

_____
Signature of Prescribing Medical Authority Date

_____
Printed Name of Medical Authority

( ) - ( ) -
Phone Fax

_____
Address

_____

Please fax completed form to school nurse. Physician requests must be renewed each school year. Any change in accommodations must be requested in writing by physician or authorized medical authority.