HISD | Nutrition Services
WE SOLVE. WE SERVE. WE NOURISH.

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 (MD/DO).*

***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 ☐ Sesame ☐ Whole Corn ☐ All Corn Derivatives

☐ 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)*

☐ Year-Round

☐ Temporary: Start _____ Stop _____

Liquids: *(choose one)*

☐ Mildly Thick (Level 2)

☐ Moderately Thick (Level 3)

☐ Extremely Thick (Level 4)

Solids: *(choose one)*

☐ Soft & Bite-Sized (Level 6)

☐ Minced & Moist (Level 5)

☐ 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.*