

# 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*)                      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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