February 26, 2018

Dear Parents/ Guardians:

Please note that Lamar CISD has received some Catfish from the Texas Department of Agriculture that we will be offering in addition to our regular Friday menu options. These dates are marked on the posted March menus. We realize some of our students may have allergies to fish and will need to be extra careful when choosing their selections through the line. In an effort to help identify this item, Food Services will be providing yellow signs to each campus to be posted on the serving line with this entrée.

Lamar CISD provides nutritious meals to all students, including those who require special diets due to medical reasons (i.e. disability, allergies, etc.). Therefore, the Texas Department of Agriculture requires that the District maintain an updated diet order on file before being able to provide these special dietary accommodations.

If your student requires dietary accommodations (or alerts posted in our point-of-sales) please follow the instructions below. To ensure that your child receives the food he/she needs to fulfill the recommended diet, please ask your doctor to complete the attached form (Physicians Request for Special Dietary Accommodations) in its entirety and send it to the school nurse. Please ensure that it is completely filled out with all the required information so Food Services can promptly process the request and begin dietary accommodations as soon as possible.

Lamar CISD requires that the attached form (Physicians Request for Special Dietary Accommodations) is updated every school year. We thank you for your support in this matter. Please direct any questions or concerns to the school nurse or the Food Services Department Dietitian at kdavis02@lcisd.org. If you would like more information, you may visit www.lcisd.org

Sincerely,
Lamar CISD Food Services
Physician's Request for Dietary Accommodations

All sections must be **completely** filled out for this form to be accepted.  School Year: ________________

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

Student Name (Last, First): ___________________________________________ Date of Birth: ___/___/____

Campus: ___________________________________________ Grade: ___________ Student ID: ___________

Parent/Guardian Name (please print): __________________________________ Phone: ___________________________

Email Address: ____________________________________________________________

I give Food Services and/or School Nurse permission to speak with the Physician listed below to discuss the dietary needs described on this form.

Signature: ___________________________________________________________________ Date: __________

B. PARENT / LEGAL GUARDIAN CAN DECLINE ACCOMMODATIONS BELOW

I/We, ______________________________(Parent/Guardian) of _________________________(Student) do not wish to participate in the Food Allergy program.  I/We release Lamar Consolidated Independent School District, including its officers and employees, from any liability arising from their negligent acts or omissions that are in any way related to my student’s food allergy.

Signature: ___________________________________________________________________ Date: __________

C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN

Does the child have a disability or anaphylactic/ life threatening food allergy?  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: __________________________________________

Medical Diagnosis: __________________________________________________________

Check Foods to be Omitted: ____ Peanuts  ____ Tree Nuts  ____ Products produced in a facility containing any nuts  ____ Soy  ____ All Soy Protein (oil, lecithin, etc.)  ____ Whole Eggs (yolk, whites)  ____ All Egg Protein (baked goods)  ____ Fluid Milk  ____ Fluid Milk & Dairy  ____ All Milk Protein (casein, whey, etc.)  ____ Fish  ____ Shellfish  ____ Wheat  ____ Other (please be specific): __________________________________________

Can the student consume foods when the allergen is an ingredient in the food product?  Yes  No

(example: whole eggs and scrambled eggs are omitted however egg as an ingredient in pancakes and waffles are allowed)

Explain: ____________________________  __________________________________________

Texture Modification

List foods that need the following texture modification. If all foods need to be prepared in this manner, indicate "ALL".

Bite size pieces: ____________________________ Finely chopped: ____________________________

Other (please be specific): __________________________________________________________

Clinic/ Facility Name: __________________________________________________________

Address: ___________________________________________________________________

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.

Physician Name (please print): __________________________________ Phone: ___________________________

Signature: ___________________________________________________________________ Date: __________

Send completed form to school nurse.  Physician request forms **MUST** be renewed each school year. Any change or discontinuation must be submitted in writing by the physician. The Food Services Department may make food substitutions, at their discretion, for individual students who do not have a disability but who are medically certified as having a special medical or dietary need.

For questions about this form please contact LCISD Food Services Dietitian: Kasandra Davis, RD, LD. Phone: 832-223-0188, Fax 832-223-0187 or email kdavis02@lcisd.org

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