

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 LCISD Child Nutrition and/or Campus 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, _____ (Parent/Guardian) of _____ (Student) do not wish to participate in the Food Allergy program. I 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: _____ Pureed: _____

Other (please be specific): _____

Clinic/ Facility Name: _____ Phone: _____

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): _____ Date: _____

Physician Signature: _____

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: Kaisha Martelly Molinar. Phone: 832-223-0188 or email kaisha.molinar@lcisd.org

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