Physician's Request for Dietary Accommodations

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

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 Child Nutrition 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. Please allow 10 business days for processing. If you have questions about this form you may contact the Child Nutrition Department at 979-277-3750.*

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: ____________________

Which meals will the child consume at school? (please circle)

Breakfast Lunch Will bring meals from home (no accommodations needed, only post alert)

I give Brenham ISD 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,We ____________________(Parent/Guardian) of ____________________(Student) DO NOT wish to participate in the Brenham ISD dietary accommodations program.

Signature: ____________________ **Date:** ____________

C. THIS SECTION IS TO BE COMPLETED BY LICENSED PHYSICIAN

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: ____________________

Medical Diagnosis (REQUIRED): ____________________

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.

Does the child have a disability or anaphylactic/ life threatening food allergy? Yes No

If yes, please list the major life activitites) affected by the disability: ____________________

Check Foods to be Omitted:

____ Peanuts ____ Tree Nuts ____ Soy ____ All Soy Protein (oil, lecithin, etc.) ____ Fish ____ Shellfish

____ Fluid Milk ____ Fluid Milk & Dairy (cheese, yogurt) ____ All Milk Protein (including baked goods) ____ Egg ____ Wheat/Gluten

____ 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): ____________________

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