HISD FOOD SERVICES

Physician's Request for Special Dietary Accommodations

Part I: to be filled out completely by parent or guardian

Name of Student (Last) :_______________________ **(First):** _______________________

Date of Birth: _____ / _____ / ______ **Student ID#:** _______________________

School Attended:_______________________ **Grade:** ____________

Which meals will the child eat at school (please circle)? **Breakfast** **Lunch** **After School Snack**

Parent / Guardian:_______________________ **Phone Number:** ____________

Email:_______________________

Does the child have a disability (circle one)? **Yes** **No**
If yes, please describe the major life activities affected by the disability:____________
If the child has a disability, Part II must be completed and signed by a Licensed Physician

I give Food Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary need described below. _______________________
Parent/Guardian's signature **Date**

Part II: to be completed ONLY by the Licensed Medical Doctor or Recognized Medical Authority (Physician's Assistant or Nurse Practitioner) who is treating the student.

Medical Condition:_______________________

Foods to be omitted:

_____ Fluid Milk (juice substituted) _____ All Dairy Products _____ All milk protein (casein, whey, etc.)

_____ Wheat _____ Gluten _____ Eggs _____ All egg protein (albumin, etc.) _____ Soy Protein

_____ Seafood _____ Corn (as major ingredient) _____ All corn additives (dextrin, caramel color, etc)

_____ Peanuts _____ All Nuts _____ All foods produced in a facility with nut containing products

_____ Other (please be specific):_______________________

Foods to be substituted: _______________________

Texture Modification: _____ **soft** _____ **minced** _____ **pureed** **Other (specify)** ____________

Supplement (circle one):
Boost Kid Essentials 1.0 **Nutren Jr. with Fiber** **Nutren Jr.** **Peptamin Jr. 1.5**
Peptamin 1.5 **Nutren 1.5** **Other:**____________

Supplement dosage per meal:
________**Breakfast** ________**Lunch** ________ **After School Snack Program (if offered)**

Name of Medical Authority (please print): _______________________

Signature:_______________________ **Date:**____________

Phone:_______________________ **Fax:**_______________________

Mailing Address:_______________________

Send completed forms to HISD Food Services, Attn: Special Diets, 6801 Bennington Street, Houston, TX 77028
Phone: 713-491-5713. Fax: 713-491-5720

Physician's requests must be renewed at the beginning of each school year. Any change of treatment must be requested in writing by the physician.