LAMAR CISD
A PROUD TRADITION | A BRIGHT FUTURE

Physician's Request for Dietary Accommodations

All sections must be **completely** filled out for this form to be accepted.

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

Student Name: _____ **Date of Birth:** ___/___/_____ **Student ID:** _____

Campus: _____ **Grade:** _____ **School Year:** _____

Parent/Guardian Name (please print): _____ **Phone:** _____

Email Address: _____

Signature: _____ **Date:** _____

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.

B. THIS SECTION TO BE COMPLETED BY LICENCED PHYSICIAN

Does the child have a disability? 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 ____ Soy ____ All Soy Protein (oil, lecithin, etc.) ____ Fish ____ Shellfish

____ Fluid Milk ____ Fluid Milk & Dairy ____ All Milk Protein (casein, whey, etc.) ____ Egg ____ Wheat

____ Other (please be specific): _____

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

(example: scrambled eggs are omitted however egg as an ingredient in pancakes is 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: _____ Telephone: _____

Address: _____

Physician Name (please print): _____

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: Kasandra Davis, RD, LD. Phone: 832-223-0188, Fax 832-223-0187 or email kdavis02@lcisd.org