BURNET Consolidated ISD

Request for Dietary Accommodation

Instructions: Part A: Parent/Guardian completes
Part B: Physician completes
Part C: School Nurse completes. Nurse to keep a copy. Scan and e-mail to the Director of Food Service.

Parent/Guardian and School Nurse will be notified after request is evaluated. Form is required annually.

PART A			
Student's Name:		Age:	Student ID:
School:	Grade:	Classroom:	
Printed Parent or Guardian's Name:		E-mail: Phone:	

PART B		
Physician licensed to practice medicine in the state of Texas is required to complete PART B and sign.		
1. Does the Child have a disability recognized by the American's with Disability Act (ADA)?	YES	NO If No, skip to Question # 3
2. If YES, please identify the disability and describe the major life activities affected by the disability.		
3. If the Child does not have a disability, does the child have a food allergy or intolerance that results in an anaphylactic reaction when exposed to the food (s) to which they have problems?	YES	NO
4. If the answer to Questions 1 or 3 is YES, please check the following that affect the child. Dairy Egg Egg White Gluten Nut(s) Soy PKU Other: Any additional information:		
5. For food texture modification. List the foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "all" (a) Cut up or chopped into bite size pieces. (b) Finely ground. (c) Pureed or Blended.		
6. Indicate any other comments about the child's eating or feeding patterns.		
_____ Licensed physician's printed or stamped name	Office Phone: Office Fax:	
_____ Licensed physician's signature		Date

PART C		
School Nurse:	Phone:	
7. Does the Child have "Individualized Health Care Plan" (IHCP).	YES	NO
8. Does the Child have a 504 Plan?	YES	NO