



Spurger ISD School Nutrition Department

Dear Parent/Guardian:

Please review the following information regarding meal modifications for children with disabilities or food allergies/intolerances.

The School Nutrition Department:

1. Will make meal modifications prescribed by a licensed physician to accommodate a disability, a food allergy/intolerance, or other medical condition that does not rise to the level of a disability.
2. Will exclude milk from the meals due to a food allergy/intolerance or for other reasons; however, parents will be responsible for providing milk substitution.

On the front of the attached form, there is further information about meal modifications that can be requested under federal regulations, and the procedures that apply to each category. Please complete the form in its entirety; incomplete information will cause your form to be sent back to you and will restart the waiting period. This form may be completed at any time during the school year; however, for information to be accurate when school begins, please turn in prior to enrollment.

Please remember these important requirements:

- **Notes, letters, and/or comments written on prescription pads cannot be accepted in lieu of required forms, only the attached form can be used to receive a meal modification.**
- All other modification requests must be signed by a parent/guardian **AND** a licensed physician.
- In order for the statement to be valid for the **2018-2019** school year.

If you have questions or need assistance, please call Leona Callaway at 409-429-3464 or callawayl@spurgerisd.org.

Sincerely,

Leona Callaway, CNP Director
Spurger Independent School District

Spurger ISD Nutrition
Program
FOOD ALLERGY/DISABILITY SUBSTITUTION REQUEST

Date _____ Student's Date of Birth _____ Student ID# _____

Student info (printed)

Last Name _____ First Name _____

Parent or Guardian Name (printed) _____

Daytime Phone _____ Email _____

Mailing address _____ City _____

I give Spurger ISD Nutrition Program permission to speak with the below named physician or recognized medical authority to discuss the dietary needs described below.

I understand it is my responsibility to renew this form should my child's nutritional needs change. To remove allergy restrictions from this student's account: A note signed by the student's physician stating that he/she no longer has the food allergy or intolerance must be submitted to the child nutrition department. This requirement is in accordance with state and federal regulations, stating that under no circumstances is the child nutrition department to revise or change a diet prescription or medical order and must document changes to any existing diet orders in writing.

Parent's Signature _____

THIS SECTION MUST BE COMPLETED BY THE STUDENT'S TREATING PHYSICIAN. PLEASE PRINT.

Does the child have an identified disability and/or life-threatening food allergy?

YES Complete Part A – Disability or Severe Life Threatening Food Allergy **NO** Complete Part B – Food Intolerance/Allergy

A. DISABILITY OR SEVERE LIFE THREATENING FOOD ALLERGY

Student has a disability and requires a special diet or food accommodation. An individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act (ADA) as a person who has physical or mental impairment that substantially limits one or more major life activities.

Student's disability: _____

Student's food allergy that is life-threatening/anaphylactic reaction (considered a disability):

Eggs: Whole Eggs Egg as an ingredient, i.e., scrambled eggs are omitted and egg as an ingredient in pancake is not allowed

Nuts: Peanuts Tree Nuts

Dairy Allergy: No fluid milk Avoid all dairy products (cheese, yogurt, ice cream) Avoid milk in all baked goods

NOTE: water is available for students.

Fish Shellfish Wheat Soy Other _____

Diabetic NOTE: *Menu selections must be made on the school calendar menu per Doctor's orders/individual health plan.*

Major life activity affected by the life threatening food allergy or disability (check all that apply) Eating Walking

Caring for one's self Seeing Hearing Speaking Breathing Learning Performing manual tasks

Foods to omit from diet: _____

Safe food substitutes*: _____

B. FOOD INTOLERANCE/ALLERGY

Student does not have a disability but is requesting a special meal or dietary accommodation. Student's allergy/intolerance to food(s) below does not result in a life threatening (anaphylactic) reaction.

Eggs: Whole Eggs Egg as an ingredient, i.e., scrambled eggs are omitted and egg as an ingredient in pancake is not

Nuts: Peanuts Tree Nuts

Lactose Intolerance/Dairy Allergy: No fluid milk* Avoid all dairy products (cheese, yogurt, ice cream) Avoid milk in all baked goods

Fish Shellfish Wheat Soy Other _____

Foods to omit from diet: _____

Safe food substitutes*: _____

*The Child Nutrition Department will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability. Water is available to all students at no charge. Ice water and cups are located in the dining area.

I certify that the above named student needs to be offered food substitutes as described above because of the student's disability/life threatening food allergy or food intolerance/allergy as indicated above.

Name of Physician _____ Telephone Number _____

Address (Street, City, State, ZIP) _____

Signature _____ Date _____

PHYSICIAN'S SIGNATURE IS REQUIRED

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