Frisco 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 _____ Zip _____

I give Frisco 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: Ice water and cups are located in the dining area, and are available to all students at no charge.

☐ 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 allowed

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

NOTE: Water is available to all students at no charge. Ice water and cups are located in the dining area.

☐ 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