SOMERSET ACADEMY TEXAS

Physician's Request for Special Dietary Accommodations

PRINT

Date: _____

School Year: _____

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

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

Student Last Name: _____ ***First Name:** _____ **Date of Birth:** ____

School: Somerset Brooks Academy **Grade:** PK **Student ID:** _____

Parent/Guardian Name: _____ **Phone:** _____

School Nurse: _____ **Phone:** _____

I give Somerset Academy Child Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below. **Parent Signature:** _____ **Date:** _____

B. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

***Does the child have a disability and/or anaphylactic/life-threatening food allergy?** ☐ YES ☐ NO *If YES selected, form must be completed and signed by licensed physician.*

***If YES, please describe the major life activities affected by the disability:** _____

***MEDICAL DIAGNOSIS:** _____

ACCOMMODATIONS NEEDED

^Soy milk is the standard substitution when Fluid Dairy Milk is omitted

I. Restrictions Needed: ☐ **NONE**

☐ No Fluid Dairy Milk^ ☐ No Dairy Products (yogurt, cheese, etc) ☐ No Milk Protein/Milk Ingredients (in baked goods, etc.)

☐ No Whole Eggs ☐ No Eggs as an ingredient

☐ No Wheat/Gluten ☐ No Soy ingredients

☐ No Peanuts ☐ No Tree Nuts *(please note that HISD does not serve peanuts or tree nuts on the regular menus)*

☐ No foods processed in a facility that contains nuts

☐ No Seafood

☐ Other (Please list) _____

Substitutions _____

II. Texture Modification: ☐ **NONE**

Duration: *(choose one)*

☐ Year-Round

☐ Temporary: Start_____Stop_____

Liquids: *(choose one)*

☐ Mildly Thick (Level 2)

☐ Moderately Thick (Level 3)

☐ Extremely Thick (Level 4)

Solids: *(choose one)*

☐ Soft & Bite-Sized (Level 6)

☐ Minced & Moist (Level 5)

☐ Pureed (Level 4)

III. Supplement: ☐ **NONE**

☐ NPO ☐ Supplement to accompany oral diet

☐ Boost Kid Essentials 1.5 ☐ Pediasure ☐ Pediasure with Fiber ☐ Pediasure with Fiber 1.5 ☐ Pediasure Enteral with Fiber 1.0

☐ Other : _____ **Supplements not listed above may take up to 6 weeks to be processed.*

Dosage Per Meal (**REQUIRED**): ____Breakfast ____Lunch ____After School Snack

IV. Therapeutic Diet Order: Please provide specifics as needed. _____

C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

I certify that the above named student needs special dietary accommodations, as described above, because of the student's disability and/or life-threatening food allergy or food intolerance/allergy, as indicated.

_____ ☐MD ☐DO ☐NP ☐PA

***Signature of Licensed Physician/Prescribing Medical Authority** Date

***Printed Name of Licensed Physician/Prescribing Medical Authority**

Phone Fax

Address

***Send completed form to school nurse. Please submit new Physician Request form each school year**. Any change or discontinuation must be submitted in writing by the physician. Please allow two business weeks for processing. Fax completed forms to (210) 541-0049. Contact mike.jones@somersetacademytx.org with questions.*

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