DORAL ACADEMY
K-8 Charter School

Physician's Request for Special Dietary Accommodations

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: ______________________ **Grade:** __________ **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. Contact respinoza@doralacademytx.com with questions.*

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