# Special Dietary Needs Information

San Angelo I.S.D. Food Service department will provide assistance to children with disabilities when diet modifications are necessary to prevent a severe, life-threatening situation or reaction. All other menu modifications request that do not result in a severe, life threatening situation or reaction will be evaluated on a case by case basis.

## Medical Statements

Federal regulations state that any menu modifications, changes, or substitutions require a signed medical statement to be furnished that provides the following information:

1. The statement must describe the child's disability or severe allergy.
2. An explanation of why the disability or allergy restricts the child's diet.
3. The major life activity affected by the disability or allergy.
4. Describes what food or beverage items must be modified or eliminated.
5. The statement must include an acceptable substitution or recommended modifications.

## Food Allergy

Generally, children with food allergies or intolerances do not have a disability as defined under either Section 504 of the Rehabilitation Act or Part b of IDEA. Child nutrition programs are not required to make food substitutions for allergies. However, if the medical authority determines that the allergic reaction may result in a severe, life threatening reaction, menu modifications will be provided.

## How to apply for assistance for Special Dietary Needs:

- Parents must obtain the Physician's Diet Modification form, complete the information in Part A, and sign and date the form.
- A licensed physician or medical authority must complete Part B and/or Part C, sign the form and/or provide a medical statement that contains the required information listed above. Attach medical statement to form.
- Return documents to your school or Food Service office at 305 Baker St.
- Updates or renewals are only required when changes need to be made.

Parents will receive written notification from the Food Service department if their child's special dietary needs request is approved or denied within 10 days of receipt of application. If you need further information or assistance please contact Kim Carter, Child Nutrition Director, at 659-3615.

San Angelo ISD Food and Nutrition Services Department
Kim Carter, Director Child Nutrition
Telephone: 325-659-3615 Fax: 325-658-4353

**PHYSICIAN'S DIET MODIFICATIONS**
**(Sections B & C to be completed by Physician)**

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

The U.S. Department of Agriculture School Meals Program requires that **ALL QUESTIONS BE ANSWERED** in order for **ANY** diet modification or substitution to be made in school meals**.**

Student Name _____ Date of Birth: _____Campus:_____

Guardian Name _____Phone:_____ E-Mail Address:_____

As parent or guardian, I give **permission for San Angelo ISD to contact the Physician's office** regarding my child's dietary needs.

Signature: _____ Date: _____

## B. PHYSICIAN'S STATEMENT FOR STUDENT WITH LIFE THREATENING FOOD ALLERGY

1. Check all **LIFE THREATENING** food allergies – Omit these foods: ☐ fluid milk ☐ peanuts ☐ tree nuts ☐ eggs
   ☐ fish ☐ shellfish ☐ wheat ☐ soy ☐ Other (please specify),_____
2. Can the student consume foods where the allergen is an **ingredient in the food product**? ___ yes __no
   (Example: scrambled eggs are omitted but egg as an ingredient in pancake is allowed)
   Explain:_____
3. Foods to substitute: (*Note: San Angelo ISD cannot honor this document unless substitutions are listed below*)
   _____

## C. PHYSICIAN'S STATEMENT FOR STUDENT WITH DISABILITIES

1. List any disability requiring meal modification: _____
2. Explanation of why this disability restricts diet:_____
3. Major life activity affected by the DISABILITY (check all that apply):
   *(Note: San Angelo ISD cannot honor this document unless at least one life activity is marked)*
   ☐ eating ☐ caring for one's self ☐ performing manual tasks ☐ walking ☐ seeing ☐ hearing ☐ speaking
   ☐ breathing ☐ learning
4. Foods to Omit: _____
5. **Foods to substitute**:(*Note: San Angelo ISD cannot honor this document unless substitutions are listed below*)
   _____

6, List foods that need the following changes in texture. If all foods need to be prepared in this manner, indicate "all".
   Cut up or chopped into bite size pieces:_____
   Finely ground:_____
   Pureed:_____

_____ _____
Physician's Signature Date

_____ _____
Clinic/Facility Name & Address Telephone

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## School Use Only

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| ☐ Request Approved | ☐ Parent Notified | **Date** |
| ☐ Request Denied | ☐ School Notified | **Signature** |

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