WESLACO INDEPENDENT SCHOOL DISTRICT
Food & Nutrition Services Department
700 S. Bridge
Weslaco, TX 78596
(956) 969-6593 Fax (956) 969-6596

SPECIAL DIET PRESCRIPTION FORM

Name of Student: _____ D.O.B.: _____ Grade: _____

School: _____ Teacher: _____ Classroom: _____

NOTE TO PARENTS/GUARDIANS: A students who need a special meal for Breakfast or Lunch must do the following:

1. Present this form signed by parent or legal guardian and by prescribing physician (U.S. Physician only).
2. Keep the diet prescription current by submitting a new form at the beginning of each school year.
3. To change a diet order, we must have written consent from the parent or legal guardian and consent from your physician.

FOR PHYSICIAN, NURSE, OR MEDICAL OFFICE STAFF:

Student Medical Diagnosis/Condition:	Under section 504 of the Rehabilitation Act of 1973, the American with Disabilities Act (ADA) of 1990, and the ADA Amendments Act of 2008, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment or is regarded as having such an impairment. **Check major life activities affected:** ☐ Walking ☐ Seeing ☐ Hearing ☐ Speaking ☐ Breathing ☐ Working ☐ Learning ☐Performing manual tasks ☐ Caring for self (including eating) ☐ Other: _____
Therapeutic Diet Prescription:	**Mechanically Altered. Check consistency requirements for food:** ☐Soft ☐Chopped ☐Ground ☐ Pureed

Food Intolerance: _____

Food Allergen: _____

Anaphylactic Reaction: □ YES □ NO

If student has life threatening allergies, check appropriate box(es) identify nature of the reaction:

☐ Ingestion ☐Contact ☐Airborne/Inhalation

Milk Allergy/Intolerance (Please indicate level of milk restriction):

☐ Milk to drink ☐ All Dairy Products including fluid milk, cheese, yogurt, margarine, dressings and baked goods

☐ Student allowed Soy Milk ☐ Student allowed Lactose Free Milk

Other information/instructions regarding the Diet or Feeding: _____

Is parent allowed to discontinue diet order without written physician consent? □ YES □ NO

Duration of time for diet: _____ Weeks _____ Months _____Until July 2020 (New prescription required the start of each school year)

_____ _____ _____

Printed Name of Physician **Signature of Physician** **Date**

Physician's address: _____ Phone # _____ Fax #_____

RELEASE OF INFORMATION:

By signing below, I _____, parent of _____authorize the Food Service Department personnel to serve my
Print Name **Print Name**
child the diet recommended by the doctor. I also authorize the release of information concerning this special diet request between the physician and the school nurse and/or Food Service personnel.

_____ _____ _____ _____

Parent/Guardian Signature Date Home Phone# Emergency Phone #

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Please fax information to:

Attention: Ms. Becky Gracia Fax # (956) 969-6596 Telephone # (956) 969-6593

YEARLY RENEWAL REQUIRED

FOR OFFICE USE ONLY: Nurse's Signature: _____ Date Received: _____ Dietitian's Signature: _____ Date Received: _____