Physician's Request for Special Accommodations for Formula & Infant Food
Galena Park ISD Student Nutrition

FRESH FOOD. MINDS.

All requests are subject to GPISD approval and provision based on policy and procedure

All Sections must be completely filled out for this form to be accepted. *Indicates required field.

DATE:_____ **SCHOOL YEAR:**_____

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

***Student Last Name:** _____ ***First Name:**_____ **Date of Birth:** ___/___/___

School:_____ **Age/Class:** _____ **Student ID:** _____

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

School Nurse: _____ **Phone:** _____

I give Health Services/Student 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 PHYSCIAN /PRESCRIBING MEDICAL AUTORITY

***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:** _____

*Qualifying Conditions/Diagnosis – Please Check all that Apply

- ☐ cardiovascular condition
- ☐ malabsorption sysdrome
- ☐ developmental delays (sensory and motor
- ☐ GI impairment
- ☐ seizure disorder requiring ketogenic
- ☐ renal disease/low mineral condition
- ☐ low maternal weight gain/loss
- ☐ inadequate growth
- ☐ neurological condition
- ☐ respirator condition
- ☐ food allergies (cow's milk, soy or intact proteins) FPIES
- ☐ other medical condition

_____

_____

- ☐ GER/GERD
- ☐ tube feeding
- ☐ prematurity/LBW
- ☐ FTT
- ☐ oral motor feeding

Formula Options:

- ☐ Similac Sensitive (lactose sensitivity or colic)
- ☐ Similac for Spit-Up (excess spit-up or reflux)
- ☐ Similac Total Comfort (digestive issues or colic)

Infant Supplement Foods: - Optional

Infant 6 to 11 months of age:
Check Foods to remove from menu

☐ Infant cereal

☐ Baby food (due to inability or delay in consuming solids)
(specify food items below)

_____

_____

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. Scan completed forms to ALGRANT@galenaparkisd.com or call 832-386-1549 with questions or return to the school nurse for further processing.*