



# FRESH FOOD. MINDS.

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

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 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: \_\_\_\_\_

\*Qualifying Conditions/Diagnosis – Please Check all that Apply

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> cardiovascular condition                 | <input type="checkbox"/> low maternal weight gain/loss                              | <input type="checkbox"/> GER/GERD           |
| <input type="checkbox"/> malabsorption syndrome                   | <input type="checkbox"/> inadequate growth  | <input type="checkbox"/> tube feeding       |
| <input type="checkbox"/> developmental delays (sensory and motor) | <input type="checkbox"/> neurological condition                                     | <input type="checkbox"/> prematurity/LBW    |
| <input type="checkbox"/> GI impairment                            | <input type="checkbox"/> respirator condition                                       | <input type="checkbox"/> FTT                |
| <input type="checkbox"/> seizure disorder requiring ketogenic     | <input type="checkbox"/> food allergies (cow's milk, soy or intact proteins ) FPIES | <input type="checkbox"/> oral motor feeding |
| <input type="checkbox"/> renal disease/low mineral condition      | <input type="checkbox"/> other medical condition                                    |   |

\_\_\_\_\_  
\_\_\_\_\_

### 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 \_\_\_\_\_

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**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](mailto:ALGRANT@galenaparkisd.com) or call 832-386-1549 with questions or return to the school nurse for further processing.**

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