

Ponder ISD Nutrition Program
FOOD ALLERGY/DISABILITY SUBSTITUTION REQUEST

Student Info (Please Print) Date _____ Student's' Date of Birth _____ Student ID # _____

Last Name _____ First Name _____

Parent or Guardian Name _____

Daytime Phone Number _____ Email _____

Mailing Address _____ City _____ Zip _____

I give Ponder ISD Nutrition Program permission to speak with the named physician or recognized medical authority to discuss the dietary needs described below. I understand it is my responsibility to renew this form should my child's nutritional needs change. To remove allergy restrictions from this students account a note must be signed by the student's physician stating he/she no longer has the food allergy or intolerance must be submitted to the child nutrition department. This requirement is in accordance with the state and federal regulations states "Under no circumstances are school food service staff to revise or change a diet prescription or medical order" and must document changes to any existing diet orders in writing.

Parent Signature _____ **Date** _____

THIS SECTION MUST BE COMPLETED BY THE STUDENT'S TREATING PHYSICIAN. PLEASE PRINT.

Does the child have an identified disability and/or life-threatening food allergy?

Yes Complete Part A – Disability or Severe Life Threatening Food Allergy

No Complete Part B – Food Intolerance/Allergy

PART A. DISABILITY OR SEVERE LIFE THREATENING FOOD ALLERGY

Student has a disability and requires a special diet or food accommodation. "Under Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment."

Student's disability: _____

Student's food allergy that is life threatening/anaphylactic reaction (considered a disability):

Eggs: Whole Eggs Egg as an ingredient, i.e.; scrambled eggs are omitted and egg as an ingredient in pancake is not allowed

Nuts: Peanuts Tree Nuts

Dairy Allergy: No fluid milk Avoid all dairy products (cheese, yogurt, ice cream) Avoid milk in all baked goods.

NOTE: Ice water and cups are located in the food area at no additional charge.

Fish **Shellfish** **Wheat** **Soy** **Other** (Please list) _____

Diabetic NOTE: Menu selections must be made on the school calendar menu per Doctor's orders/individual health plan.

Major life activity affected by the life threatening food allergy or disability (check all that apply)

Caring for one's self Eating Performing Manual Tasks Walking Seeing Hearing Speaking Breathing Learning Working

Foods to omit from diet: _____

Safe food substitutes*: _____

PART B. FOOD INTOLERANCE/ALLERGY

Student does not have a disability but is requesting a special meal or dietary accommodation. Student's allergy/intolerance to food(s) below does not result in a life threatening (anaphylactic) reaction.

Egg: Whole Eggs Egg as an ingredient, i.e.; scrambled eggs are omitted and egg as an ingredient in pancake is not allowed

Nuts: Peanuts Tree Nuts

Lactose Intolerance/Dairy Allergy: No fluid milk Avoid all dairy products (cheese, yogurt, ice cream) Avoid milk in all baked goods.

NOTE: Water is available to all students.

Fish **Shellfish** **Wheat** **Soy** **Other** (Please list) _____

Foods to omit from diet: _____

Safe food substitutes*: _____

* The Child Nutrition Department will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability.

I certify that the above named student needs to be offered food substitutes as described above because of the student's disability/life threatening food allergy or food intolerance/allergy as indicated above.

Name of Physician: _____ Telephone Number: _____

Address _____ City _____ Zip _____

PHYSICIAN'S SIGNATURE REQUIRED _____ **Date:** _____

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