GALENA PARK I.S.D.
CHILDCARE CENTER

South Campus ◊ 1906 2nd St. Galena Park, TX 77547
Phone 832·386·3760 ◊ Fax 832·386·2013

North Campus ◊ 325 Barbara Mae, Houston, TX 77015
Phone 832-386-2090 ◊ Fax 832-386-2091

Diaper Cream/Ointment Authorization Form

Child's Name:	**Date of Birth:**
Name of Medication/Cream to be applied: (can state over the counter diaper rash cream)	
Times to be applied: ☐ **When rash is present** ☐ **With every diaper change** ☐ **Other:**	**Amount to be applied:**
Special Instructions:	

Reason for medication: For diaper rash prevention or treatment
Route: Topical
Storage: Room temperature

I authorize the use of the above diaper cream/ointment on my child.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Health Care Provider Signature **Date**

_____ _____
Health Care Provider Printed **Date**

_____
Health Care Provider Phone Number

****New form must be filled out each school year****

Physician's Request for Special Dietary Accommodations 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:_____ **Grade:** _____ **Student ID:** _____

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

School Nurse: _____ **Phone:** _____

I give Health Services/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:** _____

ACCOMMODATIONS NEEDED Lactose Free milk or Soy Milk is the standard substitution when Fluid Diary Milk please prescribe under Substitutions ^

☐ No Fluid Dairy Milk^ ☐ No Dairy Products (yogurt, cheese, etc.) ☐ No Milk Protein/Milk Ingredients (in baked goods, etc.)

☐ No Whole Eggs ☐ No Eggs as an ingredient

☐ No Wheat/Gluten ☐ No Soy ingredients

☐ No Peanuts ☐ No Tree Nuts ☐ No foods processed in a facility that contains nuts ☐ No Seafood

☐ Other (Please list) _____

Substitutions _____

I. Texture Modification: ☐ **NONE**

Duration: *(choose one)*

☐ Year-Round

☐ Temporary: Start _____ Stop _____

Liquids: *(choose one)*

☐ Mildly Thick (Level 2)

☐ Moderately Thick (Level 3) ☐ Minced & Moist (Level 5)

☐ Extremely Thick (Level 4) ☐ Pureed (Level 4)

Solids: *(choose one)*

☐ Soft & Bite-Sized (Level 6)

III. Supplement: ☐ **NONE**

☐ NPO ☐ Supplement to accompany oral diet

☐ Boost Kid Essentials 1.5 ☐ Pediasure ☐ Pediasure with Fiber ☐ Pediasure with Fiber 1.5 ☐ Pediasure Enteral with Fiber 1.0

☐ Other :_____ **Supplements may take up to 6 weeks to be processed.*

Dosage Per Meal (**REQUIRED**): ____Breakfast ____Lunch ____After School Supper

IV. Therapeutic Diet Order: Please provide specifics as needed. _____

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.*

Galena Park ISD
Solicitud médica para realizarle modificaciones especiales a la dieta de un menor

Fecha: 123

No se aceptará el formulario si no se han llenado todas las secciones. El * indica dato requerido. Ciclo escolar: _____

A. ESTA SECCIÓN DEBE LLENARLA EL PADRE O TUTOR

***Nombre del estudiante:**_____ **Fecha de Nac.:** ___/___/___

Escuela:_____ **Grado:** _____ **ID:** _____ **Padre o tutor:** _____ **Teléfono:** _____

Enfermera de la escuela: _____ **Teléfono:** _____

Doy mi autorización para que los Servicios de Salud o los Servicios de Nutrición hablen con el doctor o la autoridad médica que se menciona más adelante para discutir las necesidades de alimentación que se describen a continuación:

Firma del padre o tutor:_____ **Fecha:**_____

B. ESTA SECCIÓN DEBE LLENARLA UN MÉDICO LICENCIADO O LA AUTORIDAD MÉDICA PERTINENTE

***¿Tiene el niño una discapacidad o una alergia alimentaria que podría provocarleanafilaxis o poner en peligro su vida?** ☐ SÍ ☐ NO

Si marcó SÍ, un médico licenciado debe llenar y firmar este formulario.

***Si respondió SÍ, indique las actividades importantes afectadas por la discapacidad:**_____

***DIAGNÓSTICO MÉDICO:** _____

MODIFICACIONES NECESARIAS ^La leche de lactose free la leche líquida de origen or Soy la leche

I. Restricciones necesarias: ☐ **NINGUNA**

☐ No consumir leche de lactose free ^ ☐ No consumir productos lácteos (yogur, queso, etc.) ☐ No consumir proteína láctea o ingredientes lácteos (en alimentos horneados, etc.)

☐ No consumir huevo entero ☐ No usar huevos como ingrediente

☐ No consumir trigo o gluten ☐ No consumir soya

☐ No consumir maní ☐ No consumir frutos secos *(Tenga presente que HISD no incluye maní o frutos secos en sus menús).*

☐ No consumir alimentos procesados en instalaciones donde haya habido nueces ☐ No consumir mariscos

☐ Otras (anote) _____

Alimentos substitutos _____

II. Modificación de la textura: ☐ **NINGUNA** Líquidos: *(marque una)* Sólidos: *(marque una)*

Duración: *(marque una)*

☐ Durante todo el año

☐ Temporalmente: Iniciar _____ Terminar_____

☐ Levemente espeso (Nivel 2)
☐ Medianamente espeso (Nivel 3)
☐ Sumamente espeso (Nivel 4)

☐ Blando y tamaño de bocado (Nivel 6)
☐ Molido y húmedo (Nivel 5)
☐ Hecho puré (Nivel 4)

III. Suplementos: ☐ **NINGUNA**

☐ Nil per os (No ingerir nada por vía oral) ☐ Algún suplemento acompañará la dieta oral

☐ Boost Kid Essentials 1.5 ☐ Pediasure ☐ Pediasure con fibra ☐ Pediasure con fibra 1.5 ☐ Pediasure Enteral con fibra 1.0 ☐

Otro: _____ **Podría tomar hasta 6 semanas incorporar suplementos que no se hayan indicado anteriormente.*

Dosis por alimento **(ES REQUISITO)**: ____Desayuno ____Almuerzo ____Colación al término de las clases

IV. Orden de dieta terapéutica: Por favor ofrezca datos específicos: _____

C. ESTA SECCIÓN DEBE LLENARLA UN MÉDICO LICENCIADO O LA AUTORIDAD MÉDICA PERTINENTE

Yo certifico que el estudiante que se menciona arriba necesita las modificaciones dietéticas descritas, dado que presenta una discapacidad o una alergia alimentaria severa provocada por alimentos que ponen en riesgo su vida, como ya se ha mencionado.

_____ □MD □DO □NP □PA

***Firma del doctor o autoridad médica** Fecha

_____

***Nombre del doctor o autoridad médica**

_____

Teléfono Fax Domicilio

Entregue el forma lleno a la enfermera de la escuela. Deberá presentar uno nuevo cada año. Todo cambio o terminación de tratamiento debe comunicarse por escrito, de parte del médico. El trámite toma dos semanas. Mande la forma por scan a ALGRANT@galenaparkisd.com con preguntas contacte 832-386-1549 or return to school nurse for further processing..

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 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.*