Physician's Request For Non-Standard Formula & Infant Food

School Name:		TED BY PARENT/LEGAL GUARDIAN	Date of Birth:	
Parent/Guardian Name:				
As parent or guardian, I give permission for Galena Park ISD to contact the physician's office regarding in child's dietary needs. Parent Signature:				
THIS SECTION IS TO BE COMPLETED BY LICENSED PHYSICIAN The US Department of Agriculture School Meals Program requires that ALL questions be answered in order for ANY diet modification or substitution to be made Does the child have a disability and/or life-threatening food allergy requiring diet modification? YesNoNO	As parent or guardian, I give			
The US Department of Agriculture School Meals Program requires that ALL questions be answered in order for ANY diet modification or substitution to be made Does the child have a disability and/or life-threatening food allergy requiring diet modification? Yes No Developmental behabitation Act of 1973 and the Americans with Disabilities Act 9190. define a person with the substantially limits one or more "major life activities, has a record of such impairment, or is regarded as having such impairment." Yes No If the student does NOT have a disability and/or fada allergy, this form does not need to be completed and will be disregarded Medical Diagnosis: Qualifying Conditions: (Please check all that applies) If the student does NOT have a disability and/or fada allergy, this form does not need to be completed and will be disregarded Medical Diagnosis: Cardiovascular condition Tube feeding Malabsorption/Maldigestion Cardiovascular condition FTT GER/GERD Selzure disorder GI disorder Renal disorder Respiratory condition Inadequate growth Food allergies (cow's milk, soy, or intact protein)/FPIES Orlal motor feeding issues Prematurity/LBW Similac Total Comfort (digestric issues or colid) Other: Infant Food (if orginchie) Similac for Spit-Up (direst eissues or colid) Cont eigestric issues or colid) Infant Cereal Bab	Parent Signature:		Date:	
answered in order for ANY diet modification or substitution to be made Does the child have a disability and/or life-threatening food allergy requiring diet modification? Yes No Station 504 of the Robibilition Act of 1973 and the American with Dirabilities Act of 1980, differ a person who have a physical or ment maintent which substantially limits one or more 'major life activities affected:	THIS SECTION IS TO BE COMPLET	ED BY LICENSED PHYSICIAN		
Does the child have a disability and/or life-threatening food allergy requiring diet modification? Yes No exteins 304 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, define a person with disability or any person who has a physical or ment mapairment which substantially limits one or more "major life activities, has record of such impairment, or is regarded as having such impairment." Yes No YtS, please describe the major life activities affected:	The US Department of	Agriculture School Meals Pr	ogram requires that ALL questions be	
exclor S04 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, define a person with disability as any person who has a physical or menter major menter which substantiability in any person who has a physical or menter of YES, please describe the major life activities affected: If YES, please describe the major life activities affected: Ut he student does NOT have a dabability and/or food allergy, this form does not need to be completed and will be disregarded Medical Diagnosis: Qualifying Conditions: (Please check all that applies) Ut have a dabability and/or food allergy, this form does not need to be completed and will be disregarded Medical Diagnosis: Qualifying Conditions: (Please check all that applies) Ut have a dabability and/or food allergy is a licensed Physician Cardiovascular condition Developmental delays FTT GER/GERD Seizure disorder GI disorder Respiratory condition Inadequate growth Food allergies (cow's milk, soy, or intact protein)/FPIES Orther:	answered in or	rder for ANY diet modification		
If the student does NOT have a disability and/or food allergy, this form does not need to be completed and will be disregarded Medical Diagnosis: Qualifying Conditions: (Please check off that applies) If changes or updates to diet modifications: must be provided in writing by a Licensed Physician Cardiovascular condition Developmental delays FTT GER/GERD Seizure disorder Respiratory condition Inadequate growth Food allergies (cow's milk, soy, or intact protein)/FPIES Oral motor feeding issues Prematurity/LBW Other: Sormula Options: Similac Sensitive (digestive issues or colic) Cexcessive split-up (digestive issues or colic) Cexcessive spl	Section 504 of the Rehabilitation Act of 1973 a	nd the Americans with Disabilities Act of 1990, dej	fine a person with disability as any person who has a physical or mental	
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Formula Options: Similac Sensitive (lactose sensitivity or colic) Cher:				
(lactose sensitivity or colic) (excessive spit-up) (digestive issues or colic) Other:	Other:			
Idactose sensitivity or colic) Idigestive sisues or colic) Other: Idigestive issues or colic) Infant Food: (If applicable) Check Foods to remove from the menu Infant cereal Baby food* (due to delay or inability to consume solids) Formula only, no foods *Please specify food item to omit:	Formula Options:			
Infant Food: (If applicable) Check Foods to remove from the menu Infant cereal Baby food* (due to delay or inability (due to delay or inability to consume solids) *Please specify food item to omit:	(lactose sensitivity or colic)	(excessive spit-up)		
(due to delay or inability to consume solids) to consume solids) *Please specify food item to omit:, physician for, declare the I,, physician for, declare the herein mentioned child Physician's Name Child's Name to possess the following listed Life Threatening Food Allergies and/or Disabilities. Alternate foods should be offered at school in accordance with the following guidelines. Physician Signature:	nfant Food: (If applicable)			
I,, physician for, declare the herein mentioned child Physician's Name Child's Name to possess the following listed Life Threatening Food Allergies and/or Disabilities. Alternate foods should be offered at school in accordance with the following guidelines. Physician Signature: Date:	Infant cereal	(due to delay or inability	(due to delay or inability	
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	herein mentioned child Physician's	Name Child's Name to possess the	following listed Life Threatening Food Allergies and/or	
	Physician Signature:		Date:	
Clinic Name: Clinic Address:	Clinic Name:	Clinic Address:	Clinic Address:	

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