



Manor Independent School District
Request for Dietary Accommodation

Form must be completed & signed by a Licensed Medical Authority. Once completed, turn into school nurse.
Parent/Guardian will be notified after request is evaluated. Scan & email form to: jennifer.parks@manorisd.net

SECTION A. TO BE COMPLETED BY PARENT/GUARDIAN.			
Student's Name:		Age:	Student ID:
School:	Grade:	Teacher:	
Printed Parent/Guardian's Name:		Phone/Email:	
Which meals will the student eat <u>from the school cafeteria</u> ? (circle) BREAKFAST LUNCH NONE (if student does not eat from the cafeteria it is not necessary to complete this form.)			
<i>I understand that it is my responsibility to renew this form anytime my child's medical or health needs change. Any change in accommodations must be provided in writing by physician or medical authority.</i>			
Parent/Guardian Signature:			Date:
SECTION B. TO BE COMPLETED BY AUTHORIZED MEDICAL AUTHORITY LICENSED TO PRACTICE MEDICINE IN TEXAS.			
1. Does the Child have a disability recognized by the American's with Disability Act (ADA)? <small>Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more life activities, has a record of such an impairment or is regarded as having such an impairment.</small>		YES	NO
2. If YES, please identify the <u>disability</u> and describe the <u>major life activities</u> affected by the disability.			
3. If the Child does <u>not</u> have a disability, does the child have a food allergy or intolerance that results in an anaphylactic reaction when exposed to the food (s) to which they have problems?			YES NO
4. If the answer to Questions 1 or 3 is YES, please check the food allergen/s to be omitted from the child's diet.			
Milk Allergy: <input type="checkbox"/> No liquid cow's milk (soy milk will be offered)			
Dairy Allergy: <input type="checkbox"/> Avoid all dairy products (fluid milk, cheese, yogurt, ice cream) <input type="checkbox"/> Avoid milk protein/milk ingredients (baked goods)			
Egg Allergy: <input type="checkbox"/> No whole eggs <input type="checkbox"/> No egg whites <input type="checkbox"/> No eggs as <u>ingredient</u> in baked goods			
<input type="checkbox"/> Fish <input type="checkbox"/> Soy <input type="checkbox"/> Peanuts (Please note that MISD does not serve peanuts or tree nuts on the regular menus) <input type="checkbox"/> Tree Nuts (walnuts, pecans, almonds)			
<input type="checkbox"/> Wheat			
Other (Please list): _____			
List Food/Beverages to substituted: _____			
5. Texture Modification, if applicable: <u>Solids</u> : <input type="checkbox"/> Chopped <input type="checkbox"/> Finely ground <input type="checkbox"/> Pureed/Blended <u>Liquids</u> : <input type="checkbox"/> Thin Liquids (regular liquids) <input type="checkbox"/> Nectar Thick <input type="checkbox"/> Pudding Thick			
6. Indicate any other comments about the child's eating or feeding patterns (please be specific). _____			
Licensed physician's printed or stamped name:		Office Phone:	
		Office Fax:	
Licensed physician's signature:			Date:
SECTION C. TO BE COMPLETED BY SCHOOL NURSE.			
School Nurse:		Phone:	
7. Does the Child have "Individualized Health Care Plan" (IHCP)?		YES	NO
8. Does the Child have a 504 Plan?		YES	NO