

LISD Child Nutrition Department

FOOD ALLERGY/DISABILITY SUBSTITUTION REQUEST FORM

Form is to be completed by an authorized medical professional. Return completed copy to the Child Nutrition Office.

Mailing Address: 1565 B W. Main St., Lewisville, TX 75067 Fax #: 214-626-1860

Information submitted to Health Services at enrollment is NOT received by the Child Nutrition Department. This includes food allergies and intolerances. A completed Food Allergy/Disability Substitution Request Form is the ONLY record the Child Nutrition Department receives and uses to document any special dietary needs.

PART 1: TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name:	Student ID #:	
School:	Grade Level:	DOB:
Parent/Guardian Name:	Relationship to Student:	
Email:	Daytime Phone #:	
Mailing Address:	City:	Zip Code:

Which meal(s) will your student be eating from the school cafeteria? Breakfast Lunch After School Snack

PART 2: MUST BE COMPLETED BY STUDENT'S TREATING PHYSICIAN (PLEASE PRINT)

Does the student have an identified disability, food allergy, or food intolerance requiring a special diet?

If YES: Complete PART 2



If NO: A special diet is not required

- SEVERE ALLERGY:** Student has a food allergy that is severe or causes an anaphylactic reaction
- MILD ALLERGY:** Student has a food allergy that is less severe or does not cause an anaphylactic reaction
- FOOD INTOLERANCE:** Student has a food intolerance that requires a modified diet
- DISABILITY:** Student has a disability that requires a modified diet

Please choose foods to omit from a student's diet during the school day (select all that apply).

Dairy

Eggs

Soy

- | | | |
|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Whole Eggs Only (i.e. scrambled, hard-boiled) | <input type="checkbox"/> Soy protein only |
| <input type="checkbox"/> Fluid Dairy Milk Only | <input type="checkbox"/> All menu items with eggs as an ingredient | <input type="checkbox"/> Soybean oil only |
| <input type="checkbox"/> All Plain Dairy Products Only (milk, cheese, yogurt, ice cream) | | <input type="checkbox"/> All menu items with soy ingredients (incl. soy lecithin, oil) |
| <input type="checkbox"/> All menu items with dairy as an ingredient | | |
| <input type="checkbox"/> Juice is an acceptable substitute for fluid milk for a milk allergy or intolerance | | |

Nuts

Fish/Shellfish

Wheat/Gluten

- | | | |
|----------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Fish | <input type="checkbox"/> All menu items with wheat as an ingredient |
| <input type="checkbox"/> Tree Nuts | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Celiac |
| <input type="checkbox"/> Other: Please Specify: _____ | | |
| <input type="checkbox"/> Texture Modification: Please Specify (blended, chopped, thickener, etc): _____ | | |

I certify that the above named student requires food substitutes as described above due to their disability, food allergy, or food intolerance.

Medical Authority Name (Printed): _____ Phone Number: _____

Medical Authority Signature: _____ Date: _____

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

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; or email: Program.Intake@usda.gov