

Lewisville ISD Child Nutrition
FOOD ALLERGY/ DISABILITY SUBSTITUTION REQUEST

PART 1: TO BE COMPLETED BY PARENT/GUARDIAN

Name of School: _____ Grade Level: _____ Student ID #: _____

Student Info (printed)

Last Name: _____ First Name: _____ Date of Birth: _____

Parent/Guardian Info (printed)

Name: _____ Relationship to Student: _____

Email: _____ Daytime Phone #: _____

Mailing Address: _____ City: _____ Zip Code: _____

I give Lewisville ISD Child Nutrition Program permission to speak with the below named physician or recognized medical authority to discuss the dietary needs described below.
 I understand it is my responsibility to renew this form should be child's nutritional needs change.

Parent Signature: _____ Date: _____

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

Does the student have an identified disability and/or life threatening allergy?

YES Complete PART 2A NO Complete PART 2B (reverse side) →

~~PART 2A: SEVERE LIFE THREATENING FOOD ALLERGY OR DISABILITY~~

LIFE THREATENING ALLERGY: Student has a food allergy that is life-threatening/anaphylactic reaction

Life threatening allergy (check all foods that apply)

- Eggs Peanuts Tree Nuts Milk Shellfish Fish
 Soy Wheat Corn Other _____

Can the student consume foods where the allergen is an ingredient in a product? Yes No
 (i.e. Can consume eggs in baked goods, but not scrambled eggs or can consume soy oil but not whole soy beans or TVP)

If yes, explain: _____

Foods to omit from diet: _____

Safe food substitutes*: _____

DISABILITY: Student has a disability and requires a special diet or food accommodation. An individual with a disability under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act (ADA) is a person who has physical or mental impairment that substantially limits one or more major life activities.

Student's Disability: _____

Major life activity affected by the disability (check all that apply):

- Breathing Seeing Speaking Performing manual tasks Learning Eating
 Hearing Walking Caring for one's self Other: _____

Type of Diet: Regular Soft Mechanical Chopped Blended Pureed Liquid: Clear Thickened

Other Modification: _____

Foods to omit from diet: _____

Safe food substitutes*: _____

Medical Authority Name: _____ Medical Authority Signature: _____

Medical Authority Credentials: MD DO PA NP _____ Date: _____ Phone Number: _____

For Office Use Only:
 Recommended to 504 504 In Place Implementation Date: _____

PART 2B: Non-Life Threatening Food Allergy/Intolerance

The Child Nutrition Department will work with students and their families to provide information on menu selections and ingredients, but does not make menu accommodations for food intolerances or allergies that are non-life threatening.

Allergy/Intolerance (check all foods that apply)

- Eggs Peanuts Tree Nuts Milk Shellfish Fish
 Soy Wheat Corn Other _____

Can the student consume foods where the allergen is an ingredient in a product? Yes No
(i.e. Can consume eggs in baked goods, but not scrambled eggs or can consume soy oil but not whole soy beans or TVP)
If yes, explain: _____

Medical Authority Name: _____ Medical Authority Signature: _____

Medical Authority Credentials: Date: Phone Number:
 MD DO PA NP

For Office Use Only:
 Recommended to 504 504 In Place Implementation 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

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