Crosby ISD Child Nutrition Department Brian Aubin Director, Carrie Allen RDN LDN

FAX TO: 281-328-9240 ATTENTION: DIETITIAN

PHYSICIAN'S DIET MODIFICATIONS

PLEASE COMPLETE AND RETURN IF APPLICABLE.

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Parent/GuardianName__________________________StudentName________________________________

Campus Name_________________________________ Date of Birth______________________________

As parent or guardian, I give **permission for Crosby ISD to contact the Physician's office** regarding my child's dietary needs. ________________________________ (Signature)

PART A – STUDENTS WITH LIFE THREATENING FOOD ALLERGIES ONLY COMPLETE THIS PART (If there is NO LIFE THREATENING FOOD ALLERGY, SKIP THIS SECTION, and GO TO PART B.)

PHYSICIAN'S STATEMENT Date ________________________

I______________________________, (physician) declare the child listed above to possess
Physician's Name (please PRINT)
the following LIFE THREATENING FOOD ALLERGY.

1. Life threatening food allergy – Omit these foods:
____fluid milk ____peanuts ____tree nuts ____eggs ____fish ____shellfish ____wheat ____soy

2. Can the student consume foods where the allergen is an ingredient in the food product?
___ yes____ no (Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)
Explain____

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3. Other life threatening food allergies (list all) – Omit these foods:

____

____

____

4. Explanation of why this disability restricts diet:____
5. Major life activity affected by the life threatening food allergy (check all that apply):
(***NOTE: Crosby ISD cannot honor this document unless at least one life activity is marked.)***
____ eating ____caring for one's self ____performing manual tasks ____walking ____seeing
____ hearing ____ speaking ____breathing ____learning
6. Foods to Substitute (*NOTE: Crosby ISD cannot honor this document unless substitutions are listed below.)*

____

____

____

__________________________________ __________________________________
Physician's Signature Telephone

____
Clinic/Facility Name & Address

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Parent/GuardianName__________________________StudentName________________________________

Campus Name_________________________________ Date of Birth_______________________________

As parent or guardian, I give **permission for Crosby ISD to contact the Physician's office** regarding my child's dietary needs. ________________________________ (Signature)

PART B – STUDENTS WITH DISABILITIES ONLY COMPLETE THIS PART (students with LACTOSE INTOLERANCE, SKIP THIS SECTION, COMPLETE PART C)

PHYSICIAN'S STATEMENT Date ___________________________

I________________________________, (physician) declare the child listed at top of page to possess
Physician's Name (please PRINT)
the following DISABILITY.

1. List any disability requiring meal modification:
____

2. Explanation of why this disability restricts diet:
____

3. Major life activity affected by the DISABILITY (check all that apply):
(***NOTE: Crosby ISD cannot honor this document unless at least one life activity is marked.)***
____ eating ____caring for one's self ____performing manual tasks ____walking ____seeing
____ hearing ____ speaking ____breathing ____learning ____ other, specify_____________________

4. Foods to Omit:
____
____
____

5. Foods to Substitute (*NOTE: Crosby ISD cannot honor this document unless substitutions are listed below.)*
____
____
____

____ ____
Physician's Signature Telephone

____
Clinic/Facility Name & Address

FAX TO: 281-328-9240 ATTENTION: DIETITIAN

PHYSICIAN'S DIET MODIFICATIONS

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Parent/GuardianName__________________________StudentName________________________________

Campus Name_________________________________ Date of Birth_______________________________

As parent or guardian, I give **permission for Crosby ISD to contact the Physician's office** regarding my child's dietary needs. ________________________________ (Signature)

PART C – STUDENTS WITH LACTOSE INTOLERANCE ONLY COMPLETE THIS PART

PHYSICIAN'S STATEMENT Date ___________________________

I_______________________________, (physician) declare the child listed at top of page to possess

Physician's Name (please PRINT)

LACTOSE INTOLERANCE.

Please check all that apply:

____fluid milk ____yogurt ____raw cheeses ____baked cheeses ____ice cream

In accordance with the U.S. Department of Agriculture's *Final Milk Substitutions in the School Nutrition Programs* rule, Crosby ISD can only substitute cow's milk with a milk equivalent (i.e. can no longer substitute juice) for students without a disability or life threatening allergy.

It is the policy of Crosby ISD to provide students with LACTOSE INTOLERANCE lactose free milk only.

____ ____

Physician's Signature Telephone

____

Clinic/Facility Name & Address

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

Any questions please contact Carrie Allen at 281-328-9200 ext.: 1253