

# BISD Special Meal Accommodation Form

All sections must be filled out completely for the form to be accepted.

Today's Date: \_\_\_\_\_ School Year: \_\_\_\_\_

## THIS SECTION TO BE COMPLETED BY A PARENT / LEGAL GUARDIAN

Student Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_ Student ID: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

School Nurse: \_\_\_\_\_ Phone: \_\_\_\_\_

I give Food Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## THIS SECTION TO BE COMPLETED BY A LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

1. Does the child have a disability and/or anaphylactic/life threatening food allergy?  YES  NO

2. Does the child have a non-life threatening food allergy?  YES  NO

If yes to 1 or 2, please describe the major life activities threatened: \_\_\_\_\_

**MEDICAL DIAGNOSIS:** \_\_\_\_\_

### ACCOMMODATIONS NEEDED

**I. Restrictions**  None

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> No Whole Eggs              | <input type="checkbox"/> No Eggs as an Ingredient           | <input type="checkbox"/> No Wheat/Gluten | <input type="checkbox"/> No Soy Ingredients |
| <input type="checkbox"/> No Peanuts                 | <input type="checkbox"/> No Tree Nuts                       | <input type="checkbox"/> No Seafood      | <input type="checkbox"/> No Fluid Dairy     |
| <input type="checkbox"/> No Dairy Products          | <input type="checkbox"/> No Milk Protein/Milk as Ingredient |  |   |
| <input type="checkbox"/> Other (please list): _____ |   |  |   |

**II. Texture Modifications**  None

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Mildly Thick (Level 2)  | <input type="checkbox"/> Moderately Thick (Level 3)  | <input type="checkbox"/> Extremely Thick (Level 4) | <input type="checkbox"/> Pureed (Level 4) |
| <input type="checkbox"/> Minced & Moist (Level 5)  | <input type="checkbox"/> Soft & Bite Sized (Level 6) |  |   |
| <input type="checkbox"/> Year Round or Temporary (if temporary, please list start & stop dates): _____ |  |  |   |

I certify that the above named student needs special dietary accommodations, as described above, because of the student's disability and/or life-threatening food allergy or food intolerance/allergy, as indicated.

\_\_\_\_\_  
\*Signature of Licensed Physician/Prescribing Medical Authority Date MD DO NP PA

\_\_\_\_\_  
\*Printed Name of Licensed Physician/Prescribing Medical Authority

\_\_\_\_\_  
Phone Fax Clinic Name

\_\_\_\_\_  
Address

Send completed form to school nurse. Please submit new Special Meal Accommodation Form each school year. Any change or discontinuation must be submitted in writing by the parent/legal guardian and signed off by a physician. Please allow two business weeks for processing. Contact your school nurse with questions.

\*BISD is not responsible for and cannot guarantee the accuracy of any child's diet. Products stocked by Bastrop ISD can change due to supplier changes or substitutions, or manufacturer's formulation changes. Parents/legal guardians are welcome to look at any food ingredient label or recipe upon request.

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