Gonzales Independent School District

SPECIAL MEALS REQUEST FORM

Eating and Feeding Evaluation

The Child Nutrition Department is required by the United States Department of Agriculture (USDA) to provide appropriate menu substitutions to students with life-threatening allergies (those that can cause anaphylactic reactions), or for students with disabilities that restrict their diet.

If this is a life-threatening allergy, or if your child has a disability that restricts their diet, please supply your school cafeteria manager with this SPECIAL MEALS REQUEST FORM (Parts A & B), completed in full and signed by a licensed physician.

If you child's food allergy is NOT life-threatening, the Child Nutrition Department may, although is not required, to make the requested menu substitutions. Decisions will be made on a case-by-case basis. Food substitutions may be made at the discretion of the Child Nutrition Department for individual students who do not have a disability or life-threatening allergy, but who are medically certified as having a special dietary need, or religious diet request. Before any decisions are made, this SPECIAL MEALS REQUEST FORM (Parts A & C) must be completed in full and signed by a recognized medical authority. If you have questions or concerns, please feel free to contact the Food Service Director, Ed Wayner (edward.wayner@gonzalesisd.net) or 830-672-7508

Currently, GISD's Food Service Department does not provide non-dairy or lactose-reduced/lactose-free milk substitutes to non-disabled students who cannot drink fluid milk due to a medical or special dietary need. Additionally, juice is not an approved fluid milk substitute, unless clearly stated by a physician in relation to a student with a life-threatening allergy or disability. Milk is not required to be taken as part of Offer-vs-Serve regulations and students may choose juice when offered as a fruit component in the meal.

PART A.

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

TO BE COMPLETED BY PARENT OR GUARDIAN

Student's Name		Age
Name of School	Grade Level	Classroom

☐ My child will be eating school prepared meals

Parent/Guardian Printed Name	Parent/Guardian Signature	Contact Number(s)

For students with life-threatening allergies or disabilities, continue to *PART B (TO BE COMPLETED BY PHYSICIAN'S OFFICE).*

For students who do not have a disability or life-threatening allergy, but who are medically certified as having a special dietary need, or religious preference, continue to *PART C (TO BE COMPLETED BYA RECOGNIZED MEDICAL AUTHORITY).*

Gonzales ISD is not responsible for and cannot guarantee the accuracy of any child's diet. Products stocked by Gonzales ISD can change due to supplier changes or substitutions or manufacturer's formulation changes. Cafeteria managers and staff are not trained in dietary modifications. Parents are welcome to look at any food ingredient labels or recipes. In accordance with federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the bases of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write the USDA, Director, and Office of Civil Rights, 1400 Independence Ave, SW Washington D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382. USDA is an equal opportunity provider and employer.

PART B.

For Students with Disabilities and Life-Threatening (Anaphylaxis) Allergies

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

TO BE COMPLETED BY PHYSICIAN'S OFFICE

SECTION 1.

A) **Does the Child have a Disability or a life-threatening allergy* ?** *If no, continue to PART C.* Yes ☐ No ☐

**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 major life activities, has a record of such an impairment or is regarded as having such an impairment.*

B) **The child listed above possesses the following disability or life-threatening allergy:** _____

C) **Explanation of why this disability restricts diet.**

_____

_____

D) **Major Life Activities** affected by the disability/life-threatening allergy *(check all that apply):*

☐ Caring for one's self ☐ Eating ☐ Walking ☐ Seeing ☐ Hearing

☐ Learning ☐ Speaking ☐ Breathing ☐ Performing Manual Tasks

E) **Does the child with the disability have special nutrition or feeding needs? If Yes, continue to SECTION 2. and have this form signed by a licensed physician.** Yes ☐ No ☐

SECTION 2.

A) **Foods/Beverages to omit:** _____

B) **Foods/Beverages to substitute with:** _____

C) **Can the student consume foods where the allergen(s) is an ingredient in the food product (for example, eggs are omitted, but eggs as an ingredient in pancakes is allowed?).** _____

D) **Texture Modification, if applicable:**

Liquids	☐	Thin	Solids	☐ Mechanical Soft Chopped
	☐	Thickened (Nectar)		☐ Mechanical Soft Ground
	☐	Thickened (Honey)		☐ Pureed
	☐	Thickened (Pudding)		

Please provide additional comments or information as related to diet and/or feeding techniques.

_____

_____

Printed Physician's name _____ Physician's Signature _____ Date _____

Clinic/Facility Name _____ Phone Number _____ Fax Number _____

PART C.

For Students without disabilities but with special dietary needs requiring food substitutions or modifications.

Food substitutionsor modifications for students with intolerances and allergies may be requested on this form, however, the Child Nutrition Department is not required to provide substitutions to students without disabilities or life-threatening (anaphylaxis) allergies. Such determinations are only made on a case-by-case basis.

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

This form must be completed in full and signed by a Recognized Medical Authority (Physician, Physician's Assistant or Advance Nurse Practitioner).

TO BE COMPLETED BY RECOGNIZED MEDICAL AUTHORITY

(Physician, Physician's Assistant or Advanced Nurse Practitioner)

A) Name & describe the food intolerance, allergy or special dietary need:

_____

_____

B) Describe the medical or other speical dietary reason for the need for substitution:

_____

_____

C) Foods/Beverages to omit (please be specific):

_____

_____

D) Foods/Beverages to substitute with (please be specific):

_____

_____

E) Can the student consume foods where the allergen is an ingredient in the food product (for example, eggs are omitted, but eggs as an ingredient in pancakes is allowed?) _____

F) Texture Modification, if applicable:

	☐	Thin	☐	Mechanical Soft Chopped
Liquids	☐	Thickened (Nectar)	Solids ☐	Mechanical Soft Ground
	☐	Thickened (Honey)	☐	Pureed
	☐	Thickened (Pudding)		

Please provide additional comments or information as related to diet and/or feeding techniques.

_____

_____

Printed Name of Recognized Medical Authority	Signature of Recognized Medical Authority	Date
Clinic/Facility Name	Phone Number	Fax Number