SHERMAN ISD

FOOD ALLERGY/DISABILITY SUBSTITUTION REQUEST

Date ____________________ Student's Date of Birth ______________________ Student ID# ______________________

Student info (printed) Student Last Name ___________________________ Student First Name ____

Parent or Guardian Name (printed)____

Daytime Phone ____________________ Email ____

Mailing address _________________________________City ____________________________Zip _______

- I understand that it is my responsibility to review the school menus with my child to select allergy-appropriate menu items. If my child is unable to select allergy-appropriate menu items from the published menu, I must contact the Child Nutrition Department to request a menu accommodation.
- I give Sherman ISD 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 my child's nutritional needs change. To remove allergy restrictions from this student's account, the parent/guardian must submit a signed note stating that the student no longer has the food allergy or intolerance.

Parent's Signature ____

THIS SECTION MUST BE COMPLETED BY THE STUDENT'S TREATING PHYSICIAN. Please Print

Does the child have an identified disability and/or life-threatening food allergy?

☐ **YES, Complete** Part A – Disability or Severe Life-Threatening Food Allergy ☐ **NO,** Complete Part B – Food Intolerance/Allergy

A. DISABILITY, INCLUDING *SEVERE*, LIFE THREATENING FOOD ALLERGY

Student has a disability and requires a special diet or food accommodation. An individual with a disability is described under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990 as a person with any physiological disorder or conditions, cosmetic disfigurement, or anatomical loss affecting the body's systems or any mental or psychological disorder which affects one of the major life activities. Explanation of the disability or medical condition requiring meal accommodations: ___________________________________

Student's food allergy/restrictions related to their disability:

Eggs: ☐Whole Eggs ☐ Egg as an ingredient, i.e., scrambled eggs are omitted and egg as an ingredient in pancakes is not allowed

Nuts: ☐ Peanuts ☐ Tree Nuts

Dairy Allergy: ☐ No fluid milk ☐ Avoid all dairy products (cheese, yogurt, ice cream) ☐ Avoid milk in all baked goods

NOTE: Ice water and cups are located in the dining area and are available to all students at no charge.

☐ Fish ☐ Shellfish ☐ Wheat ☐ Soy ☐ Other____

Diabetic *NOTE: Menu selections must be made on the school calendar menu per Doctor's orders/individual health plan.*

Major life activity affected by the disability (check all that apply) ☐ Eating ☐ Walking ☐ Seeing ☐ Major bodily functions

☐ Reading ☐ Hearing ☐ Speaking ☐ Breathing ☐ Learning ☐ Performing manual tasks ☐ Other

Foods to omit from diet due to allergy: ____

Safe food substitutes***(required)**____

Student ***does not have a disability but is requesting a special meal or dietary accommodation***. Student's allergy/intolerance to food(s) below ***does not*** significantly affect one or more major life activities, as defined above. The Child Nutrition Department may make reasonable accommodations, as long as accommodation requests still meet meal pattern requirement.

Eggs: ☐ Whole Eggs ☐ Egg as an ingredient, i.e., scrambled eggs are omitted and egg as an ingredient is not allowed

Nuts: ☐ Peanuts ☐ Tree Nuts

Lactose Intolerance/Dairy Allergy: ☐ No fluid milk. ☐ Avoid all dairy products (cheese, ice cream) ☐ Avoid milk in all baked goods

☐ Fish ☐ Shellfish ☐ Wheat ☐ Soy ☐ Other ____

Foods to omit from diet: ____

Safe food substitutes* (required)____

*The Child Nutrition Department will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability. Water is available to all students at no charge. Ice water and cups are located in the dining area.

I certify that the above referenced student needs to be offered food substitutes as described above because of the student's disability, food allergy, food intolerance, and/or other medical condition.

Name of Physician ____ **Telephone**_________________________________

Address (Street, City, State, ZIP) ____

PHYSICIAN'S SIGNATURE IS REQUIRED ______________________________________ Date ____________________________________