

**Request for Dietary Accommodation
Austin Independent School District
Solicitud para Acomodaciones Dietéticas
Distrito Escolar Independiente Austin**

Instructions: Parent or Guardian completes PART A. Physician completes PART B. School Nurse completes PART C. Nurse to keep a copy. Make copy for cafeteria or scan and e-mail to cafeteria. Cafeteria will contact Area Supervisor. Parent or Guardian and School Nurse will be notified after request is evaluated. Form is required annually.

Instrucciones: Padre o Tutor completa PARTE A. El Médico completa PARTE B.

Enfermera Escolar completa PARTE C. Padre o Tutor y Enfermera de la escuela serán notificados después de evaluar la solicitud. Se requiere la forma anualmente.

PART A | PARTE A

Student's Name (<i>Nombre del estudiante</i>):		Age (<i>Edad</i>):	Student ID (<i>Identificación del estudiante</i>):
School (<i>Escuela</i>):	Grade (<i>Grado</i>):	Classroom (<i>Salón</i>):	
Printed Parent or Guardian's Name (<i>Nombre de impresa del Padre o Tutor</i>):		E-mail (<i>Dirección Electrónica</i>): _____	
		Phone (<i>Teléfono</i>): _____	

PART B | PARTE B

Physician licensed to practice medicine in the state of Texas is required to complete PART B and sign.		
1. Does the Child have a disability recognized by the American's with Disability Act (ADA)?	YES	NO
If No, skip to Question # 3		
2. If YES, please identify the disability and describe the major life activities affected by the disability.		
3. If the Child does not have a disability, does the child have a food allergy or intolerance that results in an anaphylactic reaction when exposed to the food (s) to which they have problems?	YES	NO
4. If the answer to Questions 1 or 3 is YES, please check the following that affect the child. <input type="checkbox"/> Dairy <input type="checkbox"/> Egg <input type="checkbox"/> Egg White <input type="checkbox"/> Gluten <input type="checkbox"/> Nut(s) <input type="checkbox"/> Soy <input type="checkbox"/> PKU Other: _____		
Any additional information:		
5. For food texture modification. List the foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "all" (a) Cut up or chopped into bite size pieces. _____ (b) Finely ground. _____ (c) Pureed or Blended. _____		
6. Indicate any other comments about the child's eating or feeding patterns.		
Licensed physician's printed or stamped name	Office Phone: _____ Office Fax: _____	
Licensed physician's signature	Date	
PART C PARTE C		
School Nurse:	Phone:	
7. Does the Child have "Individualized Health Care Plan" (IHCP).	YES	NO
8. Does the Child have a 504 Plan?	YES	NO