School Campus: _____

Rio Grande City Consolidated Independent School District
School Special Diet Modification Request

The school special diet modification request must be submitted to Rio Grande City C.I.S.D. by the parent or guardian. **This form must be completed and signed by a Licensed Medical Authority (Physician, Physician Assistant or Advance Practice Nurse)**

Student Legal Name – Last: _____ **First**: _____ **MI**: _____

Date of Birth: _____ **Student ID#**: _____ **Grade**: _____

Parent/Guardian: _____ **Phone Number**: _____

Does this student have a disability? ☐ **Yes** ☐ **No**

The Rehabilitation Act of 1973, Section 504 (Section 504) and the American Disabilities Act (ADA) of 1990 provide regulatory guidance which defines a disability as 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. Individuals who take mitigating measures to improve or control any of the conditions recognized as a disability are still considered to have a disability and require an accommodation.

If yes, a child with a disability must be provided reasonable accommodations when that need is supported and signed by a Medical Authority who is Licensed by the State to write prescriptions.

How does this medical disability or special dietary need impact the student's diet? _____

_____

Does student have a **life threatening** food allergy? ☐ **Yes** ☐ **No**

List the food(s) to be omitted and/or substituted: _____

_____

Please note if foods require a change in texture: ☐ **chopped** ☐ **pureed** ☐ **finely ground** ☐ **blended**

Has patient and parent been counseled by or referred to a Registered Dietitian? ☐ **Yes** ☐ **No**
Please note Name & Number: _____

- The School Nutrition Services staff will make every attempt to reasonably accommodate students that have dietary restrictions that are not life threatening or not reported by a physician as a disability.
- School Nutrition Service will not make menu accommodations based on food preferences.
- Please allow a minimum of 5-7 business days for processing of requests.

Condition/Diagnosis that requires a special diet or food modification at school: _____

_____

Description of the accommodation to be made: _____

_____

*(Food items or ingredients to be omitted and/or substituted. Calorie controlled & CHO counting diets **must** be accompanied by an established meal pattern.)*

Physician or Medical Authority Signature: _____

Phone Number: _____ Fax Number: _____ Date: _____