Mansfield ISD Student Nutrition MISD **Special Dietary Request Form**

STUDENT'S NAME _____ **Date of Birth**_____ **ID #**_____

School _____ **Grade**_____

List the child's physical, mental or dietary impairment that restricts the child's diet or major life activity (REQUIRED):

_____

Please fill out all information in each applicable section. A substitution for milk is REQUIRED. Please indicate if items such as dairy, eggs, milk CAN or CANNOT be baked into products /or as an ingredient.

I. Food Allergy or Intolerance □ **Not Applicable**

Does the child have an Epi Pen at the Campus? □ YES □ NO

□ **Liquid Cow's Milk Allergy (specify the following):** *****Liquid Milk Substitution (**REQUIRED**): _____

□ **Dairy Allergy (specify the following):** □ No Yogurt □ No Cheese □ No Sour Cream □ No Butter □ No dairy/milk products allowed baked in

□ **Egg Allergy (specify the following):** □ No Whole Eggs □ No Egg Whites □ No eggs allowed baked in

□ **No Wheat** □ **No Gluten/Celiac Disease** □ **No Peanut** □ **No Tree Nut** □ **No Fish** □ **No Shellfish**

□ **No Soy Protein/Flour** □ **No Soy Oil/Lecithin** □ **No Whole Kernel Corn** □ **No Corn Flour**

□ **Other (Please list):** _____

Please identify appropriate substitutions for the foods to omit above, if appropriate: _____

_____

***Note: The Student Nutrition Dept. will attempt to accommodate the substitution as requested but reserves the right to modify the menu based on product availability.**

II. Texture Modification: □ **Not Applicable**

Liquids:	Solids:
□ Thin (Regular liquids)	□ Mechanical Soft (chopped)
□ Nectar Thick	□ Mechanical Soft (ground)
□ Honey Thick	□ Pureed (Applesauce texture)
□ Pudding Thick	

III. Therapeutic Diet Order: □ **Not Applicable**

Please state therapeutic diet: _____

I certify that the above-named student needs to be offered food substitutions as described above because of the student's disability/life threatening food allergy or food intolerance/allergy as indicated.

Prescribing Physician/Medical Authority _____

Printed Name of Medical Authority _____**DATE**_____ ☐ **MD** ☐ **DO** ☐ **PA** ☐ **NP** ☐ **SLP**

Name of Practice _____ **Phone Number** _____

I understand that if my child's medical or health needs change, it is my responsibility to alert the student nutrition department of the changes. I also give permission for the department personnel responsible for implementing my child's special diet to discuss my child's special dietary accommodations with my child's medical authority.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

EMAIL CONTACT NUMBER OF PARENT/GUARDIAN

SN Office Use only
Received by: _____ Date: _____

Revised 08.02.2019