2016-2017 MISD Food and Nutrition Services Diet Modification Request

Student's Name (Last, First): _____ Date of Birth: _____

Please return form to your school nurse upon completion by an authorized medical authority.

Please contact your school nurse or the MISD Dietitian with any questions. Phone: 972-882-5468

Section A: Medical Conditions Requiring Food Modification

I. Therapeutic Diet Order

Duration:

☐ Temporary: Start: _____ End: _____

☐ Year Round

☐ Diabetic: Carbohydrate Allowance

Breakfast: _____g Lunch: _____g Snack: _____g

☐ Cardiac: Fat: _____g Na: _____g

☐ PKU: Protein: _____g

☐ Renal: Na _____g K: _____g Phos: _____g

☐ Sodium Restriction: Na _____g

☐ Other: _____

_____

II. Texture Modification

Duration:

☐ Temporary: Start: _____ End: _____

☐ Year Round

Liquids:

☐ Thin (regular liquids)

☐ Nectar Thick

☐ Honey Thick

☐ Pudding Thick

Solids:

☐ Mechanical Soft (Chopped)

☐ Mechanical Soft (Ground)

☐ Pureed

Section B: Allergies/Intolerances

1. Is the Allergy: ☐ Non-life threatening/ mild ☐ Life Threatening (causes severe anaphylaxis)
2. Foods to omit from the diet:

☐ Seafood
☐ Egg
☐ Tree Nut
☐ Peanut
☐ Soy
☐ Fluid cow's milk
☐ All Dairy (yogurt, cheese, etc.)
☐ Corn
☐ Wheat
☐ Other: _____

_____

3. Safe food substitutions: _____

_____

4. Student requires fluid milk substitution *(Note: This does not include other dairy products such as yogurt or cheese unless indicated in the allergy section above).*

☐ Yes ☐ No

MISD offers Soy milk as a substitute for fluid milk.

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.

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

(PLEASE PRINT)

Prescribing Physician/Medical Authority Signature: _____ _____

(SIGNATURE) (DATE)

Contact Number: _____

I understand that this form will remain on file each year. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the school nurse who will then give it the to the district dietitian.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

ADDRESS/EMAIL CONTACT NUMBER OF PARENT/GUARDIAN