



- NEW Request
- CHANGE or MODIFY Existing Request
- DISCONTINUE Request

Student ID Number _____ STUDENT'S NAME (Last, First) _____ NOMBRE DEL ALUMNO (Apellido, Nombre) _____ Date of Birth
Fecha de nacimiento _____

I understand as a parent, that it is my responsibility to renew this form any time there is a change or discontinuation of dietary needs and give to the school nurse. I give Mesquite ISD FNS permission to speak with the medical authority to discuss dietary needs as ordered. Como padre, entiendo que es mi responsabilidad renovar este formulario cada vez que haya un cambio o suspensión de las necesidades dietéticas y se lo entregaré a la enfermera de la escuela. Doy permiso a Mesquite ISD FNS para que hable con la autoridad médica para analizar las necesidades dietéticas según lo ordenado.

Which meals provided by the School Cafeteria will the student eat?
 Breakfast
 Lunch
 NONE

Does the student have an identified disability? (IEP or 504 Plan)?
 IEP
 504
 No

PARENT/GUARDIAN SIGNATURE _____ **FIRMA DEL PADRE/TUTOR LEGAL** _____ **DATE** _____ **FECHA** _____ **CONTACT NUMBER OF PARENT/GUARDIAN** _____ **NUMERO DE CONTACTO DEL PADRE O TUTOR LEGAL** _____

Parent/Guardian Email Address (CLEARLY PRINT) _____ Correo electrónico del padre o tutor legal (ESCRIBA CON CLARIDAD) _____

Students with a Medical Disability/Life Threatening

Students with NO Medical Disability/Non-Life Threatening

Section A. To be Completed by Physician/Medical Authority

(Debe ser llenada por un médico o autoridad médica)

Does the student have a disability which restricts the student's diet? Yes* No

*If Yes, describe or state the student's disability or diagnosis.

Explain why it restricts the student's diet and list major life activities affected by the disability:

I. Food Allergy

Student has allergies that ARE life threatening/anaphylactic:

Yes, continue with this section No, refer to section B

Dairy Allergy :

No Yogurt No Cheese Avoid menu items with any dairy listed as an ingredient

No Fluid Dairy Milk due to Allergy Substitute with: Soy Milk Water

Egg Allergy : No Whole Eggs (such as scrambled or boiled eggs)

Avoid menu items with any egg listed as an ingredient

No Wheat No Peanut No Tree Nut No Fish No Shellfish

No Soy (soy lecithin and soy oil allowed) No Sesame

Other (Please list): _____

Safe Food Substitutions: _____

II. Texture Modification:

Special Utensils required: _____

Year Round Temporary: Start: _____ Stop: _____

Liquids:

Thin (Regular liquids)

Nectar thick

Honey Thick

Pudding Thick

Solids:

Mechanical Soft (ground)

Mechanical Soft (chopped)

Pureed (Applesauce texture)

III. Therapeutic Diet Order : (Write specifics in space provided)

Sodium Restriction: _____

Renal: _____

PKU: _____

Cardiac: _____

Diabetic: _____

Other: _____

Section B. To be Completed by Physician/Medical Authority

(Debe ser llenada por un médico o autoridad médica)

I. Food Allergy

Student has allergies/intolerances that are NOT life threatening/anaphylactic:

Dairy Allergy :

No Yogurt No Cheese Avoid menu items with any dairy listed as an ingredient

No Fluid Dairy Milk due to Allergy Substitute with: Soy Milk Water

II. Other food allergies/intolerances :

Egg Allergy : No Whole Eggs (such as scrambled or boiled eggs)

Avoid menu items with any egg listed as an ingredient

No Wheat No Peanut No Tree Nut No Fish No Shellfish

No Soy (soy lecithin and soy oil allowed) No Sesame

Other (Please specify if allergen is as a cooked ingredient or when consumed whole/fresh)

Safe Food Substitutions: _____

Section C. To be Completed by Parent/Guardian (No Medical Authority Signature Required. May assist parent in completing section)

Esta sección a tiene que llenar el padre/tutor legal (No necesita la firma de un médico. Puede brindar ayuda al padre para llenar esta sección)

Lactose Intolerance (Intolerancia a la lactosa)

No Yogurt due to Lactose Intolerance (No yogur debido a intolerancia a la lactosa)

No Cheese due to Lactose Intolerance (No queso debido a intolerancia a la lactosa)

No Fluid Dairy Milk due to Lactose Intolerance (No leche debido a intolerancia a la lactosa)

Substitute with (Sustituir con): Soy Milk (Leche de Soja) Water (Agua)

Religious/Cultural Beliefs:

(Restricciones alimenticias por creencias religiosas/culturales)

It is against district policy to flag accounts or restrict student options without medical reason.

If students are to avoid food items for religious or cultural reasons, families are encouraged to check out cafeteria menu on www.schoolcafe.com. The district dietitian is available to answer any questions regarding the products and ingredients used. Please contact the district dietitian at 972-882-5468 for any questions or concerns.

Other (Otro): _____

To be completed only by STUDENT'S TREATING PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER

I certify that the above named student needs to be offered food substitutions as described above. FNS will attempt to accommodate substitutions but reserves the right to modify the menu based on product availability.

Printed Name of Medical Authority _____ MD DO PA-C NP DATE _____

Signature of Medical Authority _____ CONTACT TELEPHONE NUMBER _____

School Nurse - PLEASE COMPLETE

Printed Name of RN, Email & Phone # _____ School _____ ORG# _____

Printed Name of School Café Manager, Email & Phone # _____