

Child Nutrition Special Diet Form 2023-2024

Parents/Guardians, please fill in the information below in print.

Student Name:	Your name:
School:	Email:
Grade:	Phone:

Which meals will student eat from the cafeteria? **Choose one:**
 Breakfast & Lunch Breakfast Only Lunch Only None, breakfast and lunch will be from home.

Which accommodation is needed? **Choose one:**
 My child needs special diet accommodations. **(Required to have medical authority signature)**
 My child needs the same dietary accommodations as received previous school year(s). **(Medical authority signature not required)**
 My child no longer needs dietary accommodations and is allowed to receive a regular meal. **(Medical authority signature not required)**
 My child needs dietary accommodations based on religious, cultural, or personal reasons. **(Medical authority signature not required)**

Parent/Guardian Signature: _____
Date: _____

Information Below is to be Completed by a Physician

Food Allergy/Intolerance:

- Dairy: **Choose One**
 Liquid milk (other forms such as yogurt and cheese are okay) **or**
 Liquid milk, yogurt, and cheese (dairy as an ingredient, such as breads/baked goods, is okay) **or**
 Dairy products in ALL foods, including liquid milk, dairy, yogurt, cheese, and as an ingredient in other foods.
- Eggs: **Choose One**
 Whole Eggs (eggs as an ingredient in other foods are okay) **or**
 Eggs in all forms (including as an ingredient in other foods)
- Other:
 Peanuts Treenuts Soy Other (please specify) _____
 Fish Shellfish Wheat/Gluten Sesame Seed

Please list preferred food substitutions (For example, lactose-free milk, gluten-free products) _____

What kind of contract will cause a reaction? Airborne Trace Cross-Contact Ingestion
Patient's food allergy/intolerance is: Non-Life Threatening Life Threatening (Anaphylaxis)

Other Dietary Restrictions/Needs

- Texture Modification: Soft Chopped Pureed Liquids Only
- Thickened Liquids: Nectar Honey Pudding
- Diabetic/Carb Restriction:
- Sodium Restriction:

Physician Signature: _____
Date: _____

Faith Schirer, RDN
Resident Dietitian
Email: fschirer@wfid.net
Phone: 940-235-1065 x 29006
Fax: 940-235-1066



PLEASE READ

Guidelines

1. The bottom portion of form **must be filled out** and **signed** by student's medical authority, such as **licensed physician, physician assistant, nurse practitioner, or allergist**, when requesting a special diet accommodations.
2. Completed forms needs to be faxed to Faith Schirer, RDN. **Fax number is 940-235-1066**. Completed forms may also be given to the school nurse. Once received, RDN will develop a modified menu.
3. If dietary restrictions need to be **changed** or **stopped** during the school year, a new form must be submitted.
4. Parent/guardians are **responsible** to notify RDN if student changes schools or has a change in their dietary restrictions.
5. RDN has the right to contact physician office to ask questions and/or clarify information on special diet form.
6. Please email Faith Schirer, RDN, for a **new** or **replacement form** at **fschirer@wfisd.net**
7. WFISD Nutrition Department will attempt to honor **non-medical request** (religious, cultural, or personal preferences) within reason. Requests will be considered on a **case-by-case basis**.

Faith Schirer, RDN
Resident Dietitian
Email: fschirer@wfisd.net
Phone: 940-235-1065 x 29006
Fax: 940-235-1066

