DALLAS INDEPENDENT SCHOOL DISTRICT | Food and Child Nutrition Services

FOOD AND CHILD NUTRITION SERVICES DIETARY REQUEST

☐ 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 Dallas ISD FCNS 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 Dallas ISD FCNS 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

X
PARENT/GUARDIAN SIGNATURE *FIRMA DEL PADRE/TUTOR LEGAL* **DATE** *FECHA* **CONTACT NUMBER OF PARENT/GUARDIAN** *NÚMERO 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

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: ☐ Plant Based 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:

Students with NO Medical Disability/Non-Life Threatening

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: ☐ Plant Based 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 intolderancia a la lactosa)
☐ No Fluid Dairy Milk due to Lactose Intolerance (No leche debido a intolerancia a la lactosa)
Substitute with (Sustituir con): ☐ Lactose free milk (Leche sin Lactosa) ☐ Water (Agua)

Religious/Cultural Beliefs Food Restrictions:
(Restricciones alimenticias por creencias religiosas/culturales)
☐ **No Pork (No Cerdo)** ☐ **No Fish (No Pescado)**
☐ **No Beef (No Res)** ☐ **No Shellfish (No Mariscos)**
☐ **No Turkey (No Pavo)** ☐ **No Milk Products (No Productos Lacteos)**
☐ **No Chicken (No Pollo)** ☐ **No Egg Products (No Derivados de Huevos)**

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. FCNS 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 Supervisor, Email & Phone #

Scan and Email form to: specialdiets@dallasisd.org
CONTACT FCNS REGISTERED DIETITIAN AT 214 932-5594 WITH QUESTIONS OR CONCERNS **REVISED NOVEMBER 2022**

DO NOT WRITE IN THIS AREA 9167370957