Community ISD DIETARY REQUEST

STUDENT'S NAME (Last, First)_____ **Date of Birth** _____ **ID #**_____

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 Child Nutrition Services office and the school nurse.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

ADDRESS/EMAIL _____

CONTACT NUMBER OF PARENT/GUARDIAN _____

Menu Modifications for Children WITH Disabilities

Children with disabilities who require changes to the basic meal are required to provide documentation with accompanying instructions from a licensed physician. This is to ensure that the modified meal is reimbursable, and to ensure that any meal modifications meet nutrition standards which are medically appropriate for the child. The physician's statement must identify:

- Child's Disability
- An explanation of why the disability restricts the child's diet
- Major life activity affected by the disability
- The food(s) to be omitted from the child's diet, and the appropriate food substitute.

Special Dietary Needs of Children WITHOUT Disabilities

Children without disabilities, but with special dietary needs requiring food substitutions or modifications, may request that the school food service meet their special nutrition needs. The school food authority will decide these situations on a case-by-case basis. Documentation with accompanying information must be provided by a recognized medical authority.

Section A. (To be completed by authorized medical authority)

(REQUIRED): Disability or severe, life threatening food allergy
Describe Student's medical condition/disability that requires a meal modification:

I. DISABILITY OR SEVERE LIFE-THREATENING FOOD ALLERGY
Student has allergies that are life threatening/anaphylactic:

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

☐ **Dairy Allergy:** ☐ No Dairy Milk ☐ No Yogurt ☐ No Cheese

☐ Avoid all dairy products even in baked goods

☐ **Milk Allergy** (Soy milk offered in place of dairy milk)

☐ **Egg Allergy:** ☐ No Whole Eggs ☐ No Egg Whites ☐ No Eggs in baked goods

☐ No Wheat ☐ No Peanut ☐ No Tree Nut ☐ No Sesame

☐ No Fish ☐ No Shellfish ☐ No Soy ☐ No Corn

☐ **Omit foods "processed in a facility" with above ✓ checked ingredients**

☐ **Other (Please list):**

***Safe Food Substitutions:**

Section B.

Food Allergy/Intolerance (NOT LIFE THREATENING)
Student without a disability but is requesting special dietary accommodation

*** PLEASE ✓ CHECK either ALLERGY or INTOLERANCE ***

☐ ***ALLERGY*** ☐ ***INTOLERANCE***

Student's allergy/intolerance to food(s) below:
Does not **result in a** ***Life Threatening/Anaphylactic reaction***

I. Dairy Allergy: ☐ No Fluid Dairy Milk ☐ No Yogurt ☐ No Cheese

☐ Avoid all dairy products even in baked goods

☐ **Lactose Intolerance** (Lactaid Milk will be offered)

☐ **Milk Allergy** (Soy milk will be offered only for milk allergy)

II. Other food allergies/intolerances:

☐ **Egg Allergy:** ☐ No Whole Eggs ☐ No Egg Whites

☐ No Eggs in baked goods ☐ No Sesame

☐ No Wheat ☐ No Peanut ☐ No Tree Nut

☐ No Fish ☐ No Shellfish ☐ No Soy ☐ No Corn

☐ Omit all foods "processed in a facility" with the above checked ingredients

☐ **Other** (Please list):

***Safe Food Substitutions:**

***Note: Child Nutrition will attempt to accommodate substitutions as requested but reserves the right to modify the menu based on products available**

Section C.

Religious/Personal Beliefs Food Restrictions:
(Only requires parent/guardian signature)

☐ **No Pork** ☐ **No Beef** ☐ **No Pork and Beef**

Section D.

For students with medical disabilities who require modifications in the texture of food items served (such as chopped, ground, or pureed food texture.

☐ **Dysphagia/Disability:** Student has difficulty eating-swallowing, chewing, drinking.

I understand that it is my responsibility to renew this form anytime my child's medical or health needs change. As parent of guardian, I give permission for Community ISD to contact the physician's office regarding my child's dietary needs.

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.

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

Prescribing Physician/Medical Authority:_____

(Signature) (Contact Phone Number)