

APPROVED DENIED

Notes: _____

SPECIAL DIET REQUEST FORM

- New** Special Diet Request
 Change Current Special Diet Request
 Renew Existing Special Diet Request
 Temporary Special Diet Request (Start _____ & End Date _____)

Student's Full Name (printed): _____ Date of Request: _____

Last: _____ First: _____ School: _____

Date of Birth: _____ Grade: _____ Student ID#: _____

Parent/Guardian Name (printed): _____

Daytime Phone # _____ Email: _____

Which meals will the student eat from the school cafeteria?

Both Breakfast and Lunch
 Breakfast Only
 Lunch Only
 None (If the student does not eat from the cafeteria, no modification will be arranged)

I understand it is my responsibility to renew this form before each school year and anytime my child's nutritional needs change. I give South Texas ISD Child Nutrition Program permission to speak with the below-named physician or recognized medical authority to discuss the dietary needs described below.

Parent/Guardian signature: _____ Date: _____

To Be Completed Only by Physicians, Physician Assistants or Nurse Practitioners

MD/DO/PA/NP Must Attach Supporting Medical Documentation to Confirm Claimed Food Allergy and/or Disability

Prescribing Medical Authority Name (printed): _____ Telephone: _____ Fax: _____

Signature: _____ Date: _____

Address (street, city, state, ZIP): _____

Part I: Non-Life Threatening Food Allergy (check ALL that apply)

DIRECTIONS: Part I to be filled out and completed ONLY by a Licensed Medical Authority treating the student:

- Part I - If the student has a Non-Life Threatening Food Allergy (*approved on a case by case basis, South Texas ISD is not required to make dietary modifications for Non-Life Threatening Food Allergies*).

Eggs: whole eggs egg as an ingredient, i.e. scrambled eggs are omitted and egg as an ingredient in pancake is not allowed

Nuts: peanuts tree nuts (walnuts, pecans, almonds, hazelnuts...etc.) sesame seeds

Milk/Dairy allergy: Avoid fluid milk only Avoid all dairy products (fluid milk, cheese, yogurt, ice cream) Avoid dairy in all baked goods

Soy: Avoid soy milk only Avoid all soy containing products Fish Shellfish Wheat

List Others: _____

Please identify the food or choice of foods to be substituted: _____

**** While the rising prevalence of childhood obesity is a serious health concern, it is NOT currently classified as a disability. Nonetheless, the STISD Child Nutrition Program provides low fat/low sugar/low sodium menus for ALL meals: therefore, a special diet request for these options would not be necessary.**

PART II. Disability & *Life-Threatening Food Allergies*; additional supporting medical documentation is required

DIRECTIONS: Part II to be filled out and completed **ONLY** by a Licensed Medical Authority treating the student:

- Part II/Section A & B - If the student has a Disability and/or Life-Threatening Food Allergy

SECTION A: DISABILITY

Check all disabilities requiring meal modifications:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Nephritis |
| <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Orthopedic Impairment | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Addiction/Alcoholism |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> HIV Disease | <input type="checkbox"/> Autism | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Emotional Disturbance | _____ |
| <input type="checkbox"/> Speech Impairment | <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Multiple Sclerosis | _____ |

Major life activity affected by DISABILITY: Note: South Texas ISD cannot honor this Request Form unless at least one life activity is marked.

- | | | | | | | |
|--|--|--|---------------------------------|----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Speaking | <input type="checkbox"/> Hearing | <input type="checkbox"/> Seeing | <input type="checkbox"/> Walking | <input type="checkbox"/> Learning | <input type="checkbox"/> Breathing |
| <input type="checkbox"/> Caring for One's Self | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Other, specify: _____ | | | | |

Diet Order: Indicate specific restrictions in space provided

Safe Food Substitutes*:

- Texture Modification**, if applicable, specify below.
- | | | | | | |
|---------|--|--|---|--|---|
| Liquids | <input type="checkbox"/> No Restrictions | <input type="checkbox"/> Thin | <input type="checkbox"/> Thickened (Nectar) | <input type="checkbox"/> Thickened (Honey) | <input type="checkbox"/> Thickened (pudding) |
| Solids | <input type="checkbox"/> No Restrictions | <input type="checkbox"/> Mechanical Soft Chopped | <input type="checkbox"/> Mechanical Soft Ground | <input type="checkbox"/> Pureed | |

*The Child Nutrition Program will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability.

SECTION B: LIFE-THREATENING FOOD ALLERGIES (FOOD ANAPHYLAXIS)

Life-threatening food allergies: ingestion contact inhalation EpiPen/Emergency Epinephrine prescribed

Eggs: whole eggs egg as an ingredient, i.e. scrambled eggs are omitted and egg as an ingredient in pancake is not allowed

Nuts: peanuts tree nuts (walnuts, pecans, almonds, hazelnuts...etc.) sesame seeds

Milk/Dairy allergy: Avoid all dairy products (fluid milk, cheese, yogurt, ice cream) Avoid dairy in all baked goods

Soy: Avoid all soy containing products Fish Shellfish Wheat

List Others: _____

Please identify the food or choice of foods to be substituted: _____

South Texas ISD Child Nutrition Program
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