2025-2026 SPECIAL DIET REQUEST FORM

PART I: To be filled out by the parent/guardian

Student's Name (Last, First): _____ **Date of Birth:** _____ **Student ID #:** _____

School Name:_____ **Daytime Phone #:** _____

Parent/Guardian Name (printed): _____

I understand it is my responsibility to renew this form before each school year and anytime my student's nutrition needs change. I give Wylie ISD Student Nutrition Department permission to speak with the Physician and/or medical authority to discuss the dietary needs described below.

Parent/Guardian Signature: _____

Part II Instructions: To be filled out and completed ONLY by a Physician or recognized Medical Authority treating student.

Part II. Disability & Food Allergy (Non-life threatening and Life Threatening)

Diagnosis or condition which restricts diet:

A. Therapeutic Diet Order:

- ☐ Diabetic- Carbohydrate Allowance Breakfast _____g Lunch _____g
- ☐ Cardiac: Fat:_____g Na:_____g
- ☐ PKU: Protein: _____g
- ☐ Renal: Na:_____g K_____g Phos_____g
- ☐ Sodium Restrictions: Na_____g
- ☐ Other:_____

B. Texture Modification:

Liquids: ☐ Thin ☐ Thickened (Nectar) ☐ Thickened (Honey) ☐ Thickened (Pudding)

Solids: ☐ Mechanical Soft Chopped ☐ Mechanical Soft Ground ☐ Pureed

C: Food Allergy (Life Threatening/Anaphylactic):

Students with food intolerance/non-life threatening allergies will have an alert placed on their student nutrition account to prevent consumption. We encourage parents and students to view school menus on the district's website for more allergy information.

Select the appropriate box based on student's allergy reaction.

- ☐ Life Threatening Allergy- Anaphylactic
- ☐ Non-Life Threatening Allergy/Food Intolerance

Milk/Dairy Allergy:	☐ Avoid fluid milk only	☐ Avoid all dairy products (cheese, yogurt, ice cream)	☐ Avoid dairy in baked goods
Eggs:	☐ Whole Eggs	☐ Egg as an ingredient (i.e. eggs used to make a recipe such as pancakes, waffles, etc.)	
Nuts:	☐ Peanuts	☐ Tree Nut (walnuts, pecans, almonds, hazelnuts...etc.)	
Soy:	☐ Avoid Soy milk only	☐ Avoid all soy containing products	
Other:	☐ Wheat	☐ Sesame	☐ Fish ☐ Shellfish

Name of Medical Authority: _____

Prescribing Medical Authority Signature:_____ Date: _____

Contact Phone Number: _____ Fax Number: _____

Physical Address: _____

To be completed by Student Nutrition Office Date Received by SN:_____ Code Entered in Skyward:_____