

SOLICITUD DE DIETA ESPECIAL 2026-2027

Favor de entregar el formulario firmado a la
enfermera de la escuela.

FORMA #1



☐ **Nueva** Solicitud de Dieta Especial

☐ **Renovar** Solicitud de Dieta Especial

☐ Solicitud de Dieta Especial **Temporal**

Fecha de Inicio: _____ Fecha de Finalizacion: _____

A. ESTA SECCION DEBE SER COMPLETADA POR EL PADRE/TUTOR.

Nombre del Estudiante: _____ Fecha de Nacimiento: _____ ID del Estudiante: _____
Escuela: _____ Grado: _____ Maestro(a): _____ Numero del Salon de Clases: _____

Informacion de contacto de los padres/tutores.

Nombre: _____ Numero de Telefono: _____ Correo Electronico: _____

Que comidas consumira el estudiante en la cafeteria de la escuela? (Marque todas las que correspondan)

☐ DESAYUNO ☐ ALMUERZO ☐ CENA ☐ NINGUNA. EL/LA ESTUDIANTE TRAERA SU PROPIA COMIDA DE CASA.

Como padre/tutor, comprendo que es mi responsabilidad renovar este formulario cuando las necesidades nutricionales de mi hijo(a) cambien. Autorizo al departamento de Weslaco ISD Food & Nutrition Services a comunicarse con el medico para analizar las modificaciones del menu que se explican a continuacion.

Firma del padre/tutor: _____ Fecha: _____

B. ESTA SECCION DEBE SER COMPLETADA POR UN MEDICO CON LICENCIA O UN PROFESIONAL MEDICO AUTORIZADO.

1. Does the student have a medical disability which affects one of the major life functions which necessitates a meal accommodation?

Under section 504 of the Rehabilitation Act of 1973, the American with Disabilities Act (ADA) of 1990, and the ADA Amendments Act of 2008, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment or is regarded as having such an impairment.

☐ YES

☐ NO

If yes, indicate the major life activities and/or bodily functions affected:

☐ Eating ☐ Walking ☐ Seeing ☐ Hearing ☐ Speaking ☐ Breathing
☐ Caring for self ☐ Performing Manual Tasks ☐ Standing ☐ Learning ☐ Other: _____

Select the appropriate meal accommodations from the options below to address the student's medical disability or special dietary need.

☐ **FOOD ALLERGY**

☐ **FOOD INTOLERANCE**

Does the student have an anaphylactic plan due to life threatening allergies?

☐ YES

☐ NO

Check all that apply:

Dairy:

☐ Avoid Fluid Dairy Milk ONLY

☐ Avoid ALL dairy products (fluid milk, cheese, yogurt, ice cream, baked goods with dairy as an ingredient)

Please Select Milk Alternative Allowed

☐ Soy Milk ☐ Lactose Free Milk ☐ Other (Avoid Nut Milk): _____

Eggs:

☐ Avoid whole eggs ONLY
(i.e. scrambled eggs)

☐ Avoid whole eggs AND all menu items with egg as an ingredient such as baked goods.

Nuts:

☐ Avoid Peanuts

☐ Avoid tree nuts (i.e. walnuts, pecans, almonds, hazelnuts, etc.)

Specify nut type(s): _____

Soy:

☐ Avoid whole soy ONLY
(i.e. tofu, edamame)

☐ Avoid whole soy AND all menu items with soy as an ingredient (i.e. soybean oil)

Corn:

☐ Avoid whole corn ONLY

☐ Avoid whole corn AND all menu items with corn as an ingredient (i.e. corn syrup)

Fish:

☐ Avoid fish

☐ Avoid shellfish (i.e. shrimp, crab, lobster)

Wheat:

☐ Avoid wheat/Gluten

Sesame:

☐ Avoid sesame and menu items with sesame as an ingredient.

Other:

THERAPEUTIC DIET PRESCRIPTION

☐ Carbohydrate Controlled: _____ g/meal; _____ g/snack

☐ Other: _____

Mechanically Altered:

Solids:

☐ Ground ☐ Chopped ☐ Pureed

Liquids:

☐ Nectar Thick ☐ Honey Thick ☐ Pudding Thick

PHYSICIAN'S INFORMATION/SIGNATURE:

Physician's Printed Name

Physician's signature

Date

Office Phone Number

Fax Number

C. THIS SECTION MUST BE COMPLETED BY WISD STAFF ONLY.

Nurse's Signature: _____ Date Received: _____ Dietitian's Signature: _____ Date Received: _____

Please email information to: Alexandra Martinez, MS, RDN, LD Email: ammartineztorres@wisd.us Phone Number: 956-969-6593