CHILD NUTRITION DEPARTMENT
SPECIAL DIETARY REQUEST FORM
2026-2027

☐ **New Dietary Request**

☐ **Renew Existing Special Diet** ☐ **Change/Modify and Existing Dietary Request**

☐ **Temporary Diet Order** **Start Date:** _____ **End Date:** _____

Part A: To be completed by Parent/Guardian

Student Name _____ Date of Birth: _____

Name of School _____ Grade: _____ School ID: _____

Part B: To be completed by Medical Authority

Diagnosis or special dietary condition which restricts diet:

Does the child have a disability? ☐ **Yes** ☐ **No**

If yes, describe the major life activities affected by the disability and why the disability restricts the child's diet.

Does the child have an EPI Pen at the Campus? ☐ **Yes** ☐ **No**

Does the child have a special nutritional or feeding needs? ☐ **Yes** ☐ **No**

If yes, complete the information below:

<u>Food Allergy or Intolerance</u>

☐ Milk Allergy ☐ No Liquid Cow's Milk

☐ Dairy Allergy ☐ No Yogurt ☐ No Cheese ☐ No Sour Cream

☐ Avoid all dairy products even baked goods

☐ Egg Allergy ☐ No Whole Eggs ☐ No Eggs Whites

☐ No Eggs in baked goods

☐ No Wheat ☐ No Gluten/Celiac Disease

☐ No Fish ☐ No Shellfish

☐ No Soy Protein/Flour ☐ No Soy Oil/Lecithin

☐ No Peanut ☐ No Tree Nut

☐ No Corn ☐ Food Allergy NOT APPLICABLE

☐ Other Please List: _____

Please identify appropriate substitutions for the foods to omit above, if appropriate: _____

BIRDVILLE ISD

Texture Modification

Liquids

- ☐ Thin (Regular Liquids)
- ☐ Nectar Thick
- ☐ Honey Thick
- ☐ Pudding Thick

Solids

- ☐ Mechanical Soft (chopped)
- ☐ Mechanical Soft (ground)
- ☐ Pureed (Applesauce texture)
- ☐ **Modification NOT APPLICABLE**

Note: The Child Nutrition Dept. will attempt to accommodate the substitution as requested but reserves the right to modify the menu based on product availability.

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.

Prescribing Physician/Medical Authority Signature X _____

Printed Name of Medical Authority _____ Date _____

Name of Practice _____ Phone Number _____

☐ MD ☐ DO ☐ PA ☐ NP ☐ SLP

Part C: To be completed by Parent/Guardian

I understand that if my child's medical or health needs change, it is my responsibility to alert the Child Nutrition Department of the changes. I also give my permission for the department personnel responsible for implementing my child's special diet to discuss my child's dietary accommodations with my child's authority. This form must be filled out completely BEFORE any dietary modifications can be made.

Parent/Guardian Signature _____ Date _____

Email of Parent/Guardian _____ Phone Number _____

Student Name _____

Office Received By: _____

Notice Sent to Manager _____ Date _____

Fax Completed Form to: 817-547-5552
Birdville ISD, Child Nutrition Department
3120 Carson Street, Haltom City, TX 76117
Telephone: 817-547-5860

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