

Child Nutrition Special Diet Form 2026-2027

Parents/Guardians, please fill in the information below in print.

Student Name:

Your name:

School:

Email:

Grade:

Phone:

Which meals will student eat from the cafeteria? **Choose one:**

☐ Breakfast & Lunch ☐ Breakfast Only ☐ Lunch Only ☐ None, breakfast and lunch will be from home.

Which accommodation is needed? **Choose one:**

☐ My child needs special diet accommodations. (Required to have medical authority signature)

☐ My child needs the same dietary accommodations as received previous school year(s). (Medical authority signature **NOT** required)

☐ My child no longer needs dietary accommodations and is allowed to receive a regular meal. (Medical authority signature **NOT** required)

Parent/Guardian Signature:

Date:

Information Below is to be Completed by a Physician

Food Allergy/Intolerance:

- Dairy: **Choose One**

☐ Liquid milk (other forms such as yogurt and cheese are okay) **or**

☐ Liquid milk, yogurt, and cheese (dairy as an ingredient, such as breads/baked goods, is okay) **or**

☐ Dairy products in ALL foods, including liquid milk, dairy, yogurt, cheese, and as an ingredient in other foods.
- Eggs: **Choose One**

☐ Whole Eggs (eggs as an ingredient in other foods are okay) **or**

☐ Eggs in all forms (including as an ingredient in other foods)
- Other:

☐ Peanuts ☐ Treenuts ☐ Soy ☐ Other (please specify) _____

☐ Fish ☐ Shellfish ☐ Wheat/Gluten ☐ Sesame Seed

Milk substitution ☐ Lactose-free milk ☐ Soy Milk ☐ Water

Food substitution _____

What kind of contract will cause a reaction? ☐ Airborne ☐ Trace Cross-Contact ☐ Ingestion

Patient's food allergy/intolerance is: ☐ Non-Life Threatening ☐ Life Threatening (Anaphylaxis)

Other Dietary Restrictions/Needs

- Texture Modification:

☐ Soft ☐ Chopped ☐ Pureed ☐ Liquids Only
- Thickened Liquids:

☐ Nectar ☐ Honey ☐ Pudding
- Diabetic/Carb Restriction:
- Sodium Restriction:

Physician Signature: _____

Date: _____

Porcha Freemantle

Assistant Director

Email: pfreemantle@wfid.net

Phone: 940-235-1065 x 29006

Fax: 940-235-1066



PLEASE READ

Guidelines

1. The bottom portion of form **must be filled out** and **signed** by student's medical authority, such as **licensed physician, physician assistant, nurse practitioner, allergist, or a clinical registered dietitian** when requesting a special diet accommodations.
2. Completed forms needs to be faxed to Farai Sithole.
Fax number is 940-235-1066. Completed forms may also be given to the school nurse. Once received, a modified menu will be developed.
3. If dietary restrictions need to be **changed** or **stopped** during the school year, a new form must be submitted.
4. Parent/guardians are **responsible** to notify Farai Sithole if student changes schools or has a change in their dietary restrictions.
5. Farai Sithole or regional dietitian has the right to contact physician office to ask questions and/or clarify information on special diet form.
6. Please email Porcha Freemantle for a **new** or **replacement form** at **pfreemantle@wfisd.net**

Porcha Freemantle
Assistant Director
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