FOOD AND CHILD NUTRITION SERVICES
DIETARY REQUEST

#__________

STUDENT'S NAME (Last, First)______________________________ Date of Birth____________ ID #______________

Section A. (To be completed by authorized medical authority)

Disability or severe, life threatening food allergy
Student's medical condition/disability (**REQUIRED**):

____
____

I. Disability or Severe Life Threatening Food Allergy
Student has allergies that are life threatening/anaphylactic:

☐ **Yes**, continue with this section ☐ **No**, refer to section B

☐ **Dairy Allergy:** ☐ No Fluid Dairy Milk ☐ No Yogurt ☐ No Cheese

☐ Avoid all dairy products even in baked goods

☐ **Milk Allergy** (Soy milk offered in place of dairy milk)

☐ **Egg Allergy:** ☐ No Whole Eggs ☐ No Egg Whites ☐ No Eggs in baked goods

☐ **No Wheat** ☐ **No Peanut** ☐ **No Tree Nut**

☐ **No Fish** ☐ **No Shellfish** ☐ **No Soy** ☐ **No Corn**

☐ **Omit foods "processed in a facility" with above √checked ingredients**

☐ **Other (Please list):**____
____
____

II. Texture Modification:

☐ Year Round ☐ Temporary: Start:__________ Stop:____________

Liquids:
☐ Thin (Regular liquids)
☐ Nectar Thick
☐ Honey Thick
☐ Pudding Thick

Solids:
☐ Mechanical Soft (chopped)
☐ Mechanical Soft (ground)
☐ Pureed (Applesauce texture)

III. Therapeutic Diet Order: (Write specifics in space provided)

☐ Diabetic: ____
____
☐ Renal: ____
☐ PKU: ____
☐ Cardiac: ____
☐ Sodium Restriction: ________________________________
☐ Other: ____
____

Section B.

Food Allergy/Intolerance (NOT LIFE THREATENING)
Student without a disability but is requesting special dietary accommodation
*** PLEASE √ CHECK either ALLERGY or INTOLERANCE ***

☐ ***ALLERGY*** ☐ ***INTOLERANCE***

Student's allergy/intolerance to food(s) below:
Does not result in a ***Life Threatening/Anaphylactic reaction***

I. ☐ **Dairy Allergy:** ☐ No Fluid Dairy Milk ☐ No Yogurt ☐ No Cheese

☐ Avoid all dairy products even in baked goods

☐ **Lactose Intolerance** (Lactaid Milk will be offered)

☐ **Milk Allergy** (Soy milk will be offered only for milk allergy)

II. Other food allergies/intolerances:

☐ **Egg Allergy:** ☐ No Whole Eggs ☐ No Egg Whites ☐ No Eggs in baked goods

☐ **No Wheat** ☐ **No Peanut** ☐ **No Tree Nut**

☐ **No Fish** ☐ **No Shellfish** ☐ **No Soy** ☐ **No Corn**

☐ **Omit all foods "processed in a facility" with the above √ checked ingredients**

☐ **Other (Please list)**:________________________________
____
____

*Safe Food Substitutions: ______________________________
____
____

***Note: Food and Child Nutrition Services will attempt to accommodate the substitution as requested but reserves the right to modify the menu based on product availability**

Section C.

Religious/Personal Beliefs Food Restrictions: (Only requires parent/guardian signature)

☐ **No Pork** ☐ **No Beef** ☐ **No Pork and Beef**

☐ **Other**:____
____

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.

Printed Name of Medical Authority ______________________________**DATE**______________ ☐ **MD** ☐ **DO** ☐ **RD** ☐ **PA** ☐ **NP** ☐ **SLP**

Prescribing Physician/Medical Authority: ______________________________ ______________________
SIGNATURE CONTACT PHONE NUMBER

I understand that it is my responsibility to renew this form **before each school year**. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the Food and Child Nutrition Services office and the school nurse.

______________________________ ______________________
PARENT/GUARDIAN SIGNATURE DATE

______________________________ ______________________
ADDRESS/EMAIL CONTACT NUMBER OF PARENT/GUARDIAN

School Nurse/Office Personnel USE ONLY

Student ID # ______________ Student Name ______________________School ______________________ORG#__________

School RN______________________ RN Email______________________ Phone #______________

School Café Supervisor______________________ Café Supervisor Email______________________ Phone #______________

Scan and Email form to: specialdiets@dallasisd.org **CONTACT FOOD AND CHILD NUTRITION SERVICES DIETITIAN AT 214 932-5594 WITH QUESTIONS OR CONCERNS**

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FOOD AND CHILD NUTRITION SERVICES
SOLICITUD DIETÉTICA

#__________

NOMBRE DEL ESTUDIANTE (Apellido, Nombre) ____________________________ Fecha de Nac.____________ ID #_______________

Sección A. (Personal médico debe completar esta parte)

Alergia letal severa o por discapacidad
Estado de salud del estudiante/discapacidad (**OBLIGATORIO**):

____

____

I. Alergia letal severa o por discapacidad
Las alergias del estudiante son letales/anafilácticas:

☐ **Sí**, continúe en esta sección ☐ **No**, pase a la sección B

☐ **Alergia a lácteos:** ☐ No Leche de vaca líquida ☐ No Yogur ☐ No queso

☐ Evitar todos los lácteos aun en productos horneados

☐ **Alergia a la leche** (leche de soya en lugar de leche de vaca)

☐ **Alergia a los huevos:** ☐ No entero ☐ No clara ☐ No huevos en productos horneados

☐ **No trigo** ☐ **No maní** ☐ **No nueces en general**

☐ **No pescado** ☐ **No mariscos** ☐ **No soya** ☐ **No maíz**

☐ **Evite todos los alimentos "procesados" que contengan los ingredientes marcados √**

☐ **Otro (favor de anotar):**_____________________________________

____

____

II. Modificación de la textura:

☐ todo el año ☐ temporal: comienza:___________ termina:_____________

Líquidos:	Sólidos:
☐ Aguado (líquido regular)	☐ Mecánico suave (picado)
☐ néctar espeso	☐ Mecánico suave (molido)
☐ Miel espesa	☐ Puré (como el puré de manzana)
☐ Pudín espeso	

III. Orden para dieta terapéutica: (especifique en el espacio más abajo)

☐ Diabético (a): ____

____

☐ Renal: ____

☐ PKU: ____

☐ Cardíaco: ____

☐ Restricción de sodio: ____

☐ Otro: ____

____

Sección B.

Alergia/intolerancia a alimentos (NO LETALES)
Estudiante no tiene discapacidad pero solicita modificación especial a su dieta

*** USE UN √ PARA CHECAR ALERGIA o INTOLERANCIA ***

☐ ***ALERGIA*** ☐ ***INTOLERANCIA***

El estudiante tiene alergia/intolerancia a los siguientes alimentos:
No es ***Letal/reacción anafiláctica***

I. ☐ **Alergia a lácteos:** ☐ No Leche de vaca líquida ☐ No Yogur ☐ No queso

☐ Evitar todos los productos lácteos hasta en productos horneados

☐ **Intolerancia a la lactosa** (leche Lactaid estará disponible)

☐ **Alergia a la leche** (leche de soya en lugar de leche de vaca solo para la alergia a la leche)

II. Otras alergias/intolerancia a los alimentos:

☐ **Alergia a huevos:** ☐ No enteros ☐ No claras ☐ No huevos en productos horneados

☐ **No trigo** ☐ **No maní** ☐ **No nueces en general**

☐ **No pescado** ☐ **No mariscos** ☐ **No soya** ☐ **No maíz**

☐ **Evite todos los alimentos "procesados" que contengan los ingredientes marcados √**

☐ **Otro (favor de anotar)**:_________________________________

____

*Sustituciones seguras: ____

____

____

***Importante: los Servicios de alimentos y nutrición infantil hará lo posible para sustituir los alimentos como se han indicado pero se reserva el derecho de modificar el menú en base a la disponibilidad de los productos.**

Sección C.

Restricciones en los alimentos debido a creencias religiosas/personales (solo necesita la firma de los padres o tutores legales)

☐ **No cerdo** ☐ **No res** ☐ **No cerdo y res**

☐ **Otro**:____

____

Declaro que el estudiante nombrado arriba necesita que se sustituyan los alimentos aquí mencionados debido a su alergia por discapacidad, alergia letal a los alimentos o intolerancia/alergia.

Nombre impreso del representante médico______________________________**FECHA**______________ ☐ **MD** ☐ **DO** ☐ **RD** ☐ **PA** ☐ **NP** ☐ **SLP**

Doctor que hizo el diagnóstico: _________________________________ _________________________
FIRMA NÚMERO DE TELÉFONO

Entiendo que es mi responsabilidad renovar esta forma **antes de que empiece el nuevo año escolar**. Entiendo que las necesidades médicas o de salud de mi estudiante cambian y que es mi responsabilidad presentar la documentación del doctor de mi estudiante ante los Servicios de alimentos y nutrición infantil y a la enfermera de la escuela.

____ _________________________
FIMA DEL PADRE O TUTOR LEGAL FECHA

____ _________________________
DIRECCIÓN/CORREO ELECTRÓNICO NÚMERO DE TELÉFONO

School Nurse/Office Personnel USE ONLY

Student ID # ________________ Student Name ______________________________School ______________________ORG#__________

School RN_____________________________ RN Email____________________________________ Phone #________________

School Café Supervisor_________________________ Café Supervisor Email______________________________ Phone #________________

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