

# FOOD AND CHILD NUTRITION SERVICES DIETARY REQUEST

- NEW Request  
 CHANGE or MODIFY Existing Request  
 DISCONTINUE Request

Student ID Number \_\_\_\_\_ STUDENT'S NAME (Last, First) NOMBRE DEL ALUMNO (Apellido, Nombre) \_\_\_\_\_ Date of Birth Fecha de nacimiento \_\_\_\_\_

I understand as a parent, that it is my responsibility to renew this form **any time there is a change or discontinuation of dietary needs** and give to the school nurse. I give Dallas ISD FCNS permission to speak with the medical authority to discuss dietary needs as ordered. *Como padre, entiendo que es mi responsabilidad renovar este formulario cada vez que haya un cambio o suspensión de las necesidades dietéticas y se lo entregaré a la enfermera de la escuela. Doy permiso a Dallas ISD FCNS para que hable con la autoridad médica para analizar las necesidades dietéticas según lo ordenado.*

Which meals provided by the School Cafeteria will the student eat?

Breakfast  
 Lunch  
 NONE

Does the student have an identified disability? (IEP or 504 Plan)?

IEP  
 504  
 No

**PARENT/GUARDIAN SIGNATURE FIRMA DEL PADRE/TUTOR LEGAL** \_\_\_\_\_ **DATE FECHA** \_\_\_\_\_ **CONTACT NUMBER OF PARENT/GUARDIAN NUMERO DE CONTACTO DEL PADRE O TUTOR LEGAL** \_\_\_\_\_

Parent/Guardian Email Address (CLEARLY PRINT) Correo electrónico del padre o tutor legal (ESCRIBA CON CLARIDAD) \_\_\_\_\_

### Students with a Medical Disability/Life Threatening

**Section A. To be Completed by Physician/Medical Authority (Debe ser llenada por un médico o autoridad médica)**

Does the student have a disability which restricts the student's diet?  Yes\*  No

\* **If Yes**, describe or state the student's disability or diagnosis. Explain why it restricts the student's diet and list major life activities affected by the disability:

\_\_\_\_\_

#### I. Food Allergy

Student has allergies that **ARE** life threatening/anaphylactic:

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

##### Dairy Allergy:

No Yogurt  No Cheese  Avoid menu items with any dairy listed as an ingredient  
 No Fluid Dairy Milk due to Allergy Substitute with:  Soy Milk  Water

##### Egg Allergy:

No Whole Eggs (such as scrambled or boiled eggs)  
 Avoid menu items with any egg listed as an ingredient  
 No Wheat  No Peanut  No Tree Nut  No Fish  No Shellfish  
 No Soy (soy lecithin and soy oil allowed)

Other (Please list): \_\_\_\_\_

Safe Food Substitutions: \_\_\_\_\_

#### II. Texture Modification: Special Utensils required:

Year Round  Temporary: Start: \_\_\_\_\_ Stop: \_\_\_\_\_

##### Liquids:

Thin (Regular liquids)  
 Nectar thick  
 Honey Thick  
 Pudding Thick

##### Solids:

Mechanical Soft (ground)  
 Mechanical Soft (chopped)  
 Pureed (Applesauce texture)

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

- Sodium Restriction: \_\_\_\_\_  
 Renal: \_\_\_\_\_  
 PKU: \_\_\_\_\_  
 Cardiac: \_\_\_\_\_  
 Diabetic: \_\_\_\_\_  
 Other: \_\_\_\_\_

### Students with NO Medical Disability/Non-Life Threatening

**Section B. To be Completed by Physician/Medical Authority (Debe ser llenada por un médico o autoridad médica)**

#### I. Food Allergy

Student has allergies/intolerances that are **NOT** life threatening/anaphylactic:

##### Dairy Allergy:

No Yogurt  No Cheese  Avoid menu items with any dairy listed as an ingredient  
 No Fluid Dairy Milk due to Allergy Substitute with:  Soy Milk  Water

##### II. Other food allergies/intolerances:

##### Egg Allergy:

No Whole Eggs (such as scrambled or boiled eggs)  
 Avoid menu items with any egg listed as an ingredient

No Wheat  No Peanut  No Tree Nut  No Fish  No Shellfish

No Soy (soy lecithin and soy oil allowed)

Other (Please specify if allergen is as a cooked ingredient or when consumed whole/fresh)

\_\_\_\_\_

Safe Food Substitutions: \_\_\_\_\_

#### Section C. To be Completed by Parent/Guardian (No Medical Authority Signature Required. May assist parent in completing section).

Esta sección a tiene que llenar el padre/tutor legal (No necesita la firma de un médico. Puede brindar ayuda al padre para llenar esta sección)

##### Lactose Intolerance (Intolerancia a la lactosa)

No Yogurt due to Lactose Intolerance (No yogur debido a intolerancia a la lactosa)  
 No Cheese due to Lactose Intolerance (No queso debido a intolerancia a la lactosa)  
 No Fluid Dairy Milk due to Lactose Intolerance (No leche debido a intolerancia a la lactosa)  
 Substitute with (Sustituir con):  Lactose free milk (Leche sin Lactosa)  Water (Agua)

##### Religious/Cultural Beliefs Food Restrictions: (Restricciones alimenticias por creencias religiosas/culturales)

- No Pork (No Cerdo)  No Fish (No Pescado)  
 No Beef (No Res)  No Shellfish (No Mariscos)  
 No Turkey (No Pavo)  No Milk Products (No Productos Lacteos)  
 No Chicken (No Pollo)  No Egg Products (No Derivados de Huevos)

Other (Otro): \_\_\_\_\_

**To be completed only by STUDENT'S TREATING PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER** I certify that the above named student needs to be offered food substitutions as described above. FCNS will attempt to accommodate substitutions but reserves the right to modify the menu based on product availability.

Printed Name of Medical Authority \_\_\_\_\_  MD  DO  PA-C  NP \_\_\_\_\_ DATE \_\_\_\_\_

Signature of Medical Authority \_\_\_\_\_ CONTACT TELEPHONE NUMBER \_\_\_\_\_

#### School Nurse - PLEASE COMPLETE

Printed Name of RN, Email & Phone # \_\_\_\_\_ School \_\_\_\_\_ ORG# \_\_\_\_\_

Printed Name of School Café Supervisor, Email & Phone # \_\_\_\_\_