Fort Worth ISD Child Nutrition Services

DIETARY REQUEST FORM

STUDENT'S NAME (Last, First)_____ **Date of Birth**_____ **ID #**_____

School _____ **Grade**_____

Section A. (To be completed by authorized medical authority) Disability or Severe, Life Threatening Food Allergy

I. Disability or Severe Life Threatening Food Allergy
Student has allergies that are life threatening/anaphylactic:
□ **Yes**, continue with Section A □ **No**, refer to Section B

Milk Allergy □ No liquid cow's milk (Soy milk offered in place of dairy milk)
Dairy Allergy □ No Yogurt □ No Cheese □ Sour Cream
□ Avoid all dairy products even in baked goods

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**
□ **Other (Please list):**

_____
_____
_____

II. Texture Modification:

Liquids:	Solids:
□ Thin (Regular liquids)	□ Mechanical Soft (chopped)
□ Nectar Thick	□ Mechanical Soft (ground)
□ Honey Thick	□ Pureed (Applesauce texture)
□ Pudding Thick	

III. Therapeutic Diet Order: (Write specifics in space provided)
Please state therapeutic diet (Ex. Celiac):_____
_____
_____
_____

Section B. Food Allergy/Intolerance (NOT LIFE THREATENING)

Student without a disability or life threatening food allergy but is requesting special dietary accommodation.

I. **Lactose Intolerance** □ Lactaid Milk will be provided
Milk Allergy □ Soy milk will be offered only for milk allergy
Dairy Allergy: □ No Yogurt □ No Cheese □ No Sour Cream
□ Avoid all dairy products even in baked goods

II. **Other food allergies:**
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**

□ **Other (please list):**

_____
_____

*Safe Food Substitutions: _____
_____
_____

***Note: 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. Other requests*: _____
_____
_____

*We cannot guarantee accommodation of all requests.

Which meals will the student eat from the school cafeteria?
□ Breakfast □ Lunch

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

Name of Practice_____

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 to the FWISD Child Nutrition Services office. I also give permission for the department personnel responsible for implementing my child's special diet to discuss my child's special dietary accommodations with my child's medical authority.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
ADDRESS/EMAIL CONTACT NUMBER OF PARENT/GUARDIAN

School Nurse – PLEASE COMPLETE

Student ID # _____ Student Name _____ School _____ ORG#_____

School RN_____ RN Email_____ Phone #_____

School Café manager_____ Café manager Email_____ Phone #_____

Scan and Email form to: dietitians@fwisd.org **CONTACT FOOD AND CHILD NUTRITION SERVICES DIETITIAN AT 817-814-3500 WITH QUESTIONS OR CONCERNS.**