



Fort Worth ISD Child Nutrition Services Dietary / Allergy Request Form
Return completed form to the school nurse

1559466938

- 1. Parent/Guardian: complete Section A. Sign and date form (required for processing)
2. Medical Authority: complete Section B. Print, sign and date form (required for processing)
3. Return completed form to the school nurse
4. Dietitians will review and process dietary requests in the order in which they are received
5. Incomplete form will be returned to the school nurse for parent/guardian completion

Nutrition, carbohydrate content, and allergen information is available via MealViewer to help you plan your child's meals in a way that fits with your dietary and religious preferences, no dietary request form is needed. MealViewer can be accessed here: https://schools.mealviewer.com/district/FortWorthISD OR users can download the MealViewer To Go App available for Apple and Android devices.

SECTION A. To be Completed by Parent/Guardian

Student ID Number, Student's Name (Last, First), Date of Birth

Request Type, Which meals provided by the School Cafeteria will the student eat?, Does the student have an identified disability? (IEP or 504 Plan?)

Parent/Guardian Email Address (CLEARLY PRINT)

Parent Requests that are not due to a medical disability. Please Note: Nutrition Services may attempt to accommodate cultural/personal preferences but are NOT required by law to do so. These accommodations depend on product availability on the daily serving line.

This form must be completed at the start of each school year and any time there is a change or discontinuation of dietary needs during the school year. Annual completion of this form by the student's medical authority ensures that current nutritional needs are being communicated.

PARENT/GUARDIAN SIGNATURE, Date, Phone number of Parent/Guardian

SECTION B. To be Completed by Physician/Medical Authority

TEXTURE MODIFICATION:

Year Round, Temporary, Liquids, Solids

ALLERGIES (Select all that apply):

EGG, DAIRY, FISH OR SHELLFISH, WHEAT / GLUTEN, CORN, NUTS, SOY, 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. Name of Medical Authority, Prescribing Physician/Medical Authority Signature, Phone Number

School Nurse/Office Personnel USE ONLY: Student ID, Student Name, School Number, School Name, School RN Name, School RN Phone Number, School RN Email