Fort Worth INDEPENDENT SCHOOL DISTRICT

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 ☐ New ☐ Change/Modify ☐ Discontinue

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 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 and intolerance but are NOT required by law to do so. These accommodations depend on product availability on the daily serving line. ☐ **Vegan** ☐ **Vegetarian** ☐ **No Pork** ☐ **No Beef** ☐ **Other**

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.
I give Fort Worth ISD Child Nutrition Services permission to speak with the medical authority to discuss dietary needs as ordered.

X **PARENT/GUARDIAN SIGNATURE** | **Date** | **Phone number of Parent/Guardian**

SECTION B. To be Completed by Physician/Medical Authority

TEXTURE MODIFICATION:

☐ Year Round ☐ Temporary: Start: _____ Stop: _____

Special Utensils required: _____

Liquids: ☐ Thin (Regular liquids) ☐ Mildly thick ☐ Moderately thick ☐ Extremely thick

Solids: ☐ Regular ☐ Soft & Bite-Sized ☐ Minced & Moist ☐ Pureed

ALLERGIES - Indicate severity and select all that apply:

SEVERITY: ☐ Food Intolerance ☐ Food Allergy ☐ *Life Threatening Food Allergy - Check appropriate box: ☐ Ingestion ☐ Contact ☐ Inhalation

EGG
- ☐ Whole eggs such as scrambled eggs or hard cooked eggs
- ☐ Baked goods with any egg listed as an ingredient

DAIRY
- ☐ All food/beverages with milk listed as an ingredient including baked goods
- ☐ Cheese and recipes with cheese listed as an ingredient
- ☐ Yogurt
- ☐ Fluid Milk (Substitution: ☐ Lactose-free milk ☐ Water)

FISH OR SHELLFISH
- ☐ Fish
- ☐ Shellfish

WHEAT / GLUTEN
- ☐ Recipes with wheat listed as an ingredient
- ☐ Recipes with Gluten (wheat, barley, rye, triticale) listed as an ingredient

CORN
- ☐ Whole corn such as corn kernels, tortilla chips, corn muffin
- ☐ Recipes with corn / corn products listed as an ingredient

NUTS
- ☐ Peanuts
- ☐ Tree Nuts specify: _____

SOY
- ☐ Soy Lecithin
- ☐ Soy Protein (concentrate, hydrolyzed, isolate)
- ☐ Menu items with any soy listed as an ingredient

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.

Name of Medical Authority: _____ (PLEASE PRINT) ☐ MD ☐ DO ☐ RD ☐ PA ☐ NP ☐ SLP

Prescribing Physician/Medical Authority Signature: _____ (SIGNATURE) _____ (DATE)

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: _____