2020-2021 SPECIAL DIET REQUEST FORM

☐ APPROVED ☐ DENIED
Notes: ______________________________
____

☐ ***New*** Special Diet Request ☐ ***Change*** Current Special Diet Request ☐ ***Renew*** Existing Special Diet Request ☐ ***Temporary*** Special Diet Request (Start ______ & End Date ______)

Student's F ull Name (printed): Date of Request: ______________________

Last: ______________________ First: ______________________ School: ______________________

Date of Birth: ______________________ Grade: ______________________ Student ID#: ______________________

Parent/Guardian Name (printed): ____

Daytime Phone # ______________________ Email: ____

Which meals will the student eat from the school cafeteria?

☐ Both Breakfast and Lunch ☐ Breakfast Only ☐ Lunch Only ☐ None (If the student does not eat from the cafeteria, no modification will be arranged)

I understand it is my responsibility to renew this form before each school year and anytime my child's nutritional needs change. *I give Sharyland ISD Child Nutrition Program permission to speak with the below-named physician or recognized medical authority to discuss the dietary needs described below.*

Parent/Guardian signature: ______________________________________ Date: ______________________

To Be Completed Only by Physicians, Physician Assistants or Nurse Practitioners

MD/DO/PA/NP Must Attach Supporting Medical Documentation to Confirm Claimed Food Allergy and/or Disability

Prescribing Medical Authority Name (printed): ______________________ Telephone: ______________ Fax: ______________

Signature: ______________________________________ Date: ______________________

Address (street, city, state, ZIP): ____

Part I: Non-Life Threatening Food Allergy (check ALL that apply)

<u>DIRECTIONS</u>: Part I to be filled out and completed ONLY by a Licensed Medical Authority treating the student:

- Part I - If the student has a Non-Life Threatening Food Allergy (***approved on a case by case basis, Sharyland ISD is not required to make dietary modifications for Non-Life Threatening Food Allergies***).

Eggs: ☐ whole eggs ☐ egg as an <u>ingredient</u>, i.e. scrambled eggs are omitted and egg as an ingredient in pancake is not allowed

Nuts: ☐ peanuts ☐ tree nuts (walnuts, pecans, almonds, hazelnuts…etc.) ☐ sesame seeds

Milk/Dairy allergy: ☐ Avoid fluid milk only ☐ Avoid all dairy products (fluid milk, cheese, yogurt, ice cream) ☐ Avoid dairy in all baked goods

Soy: ☐ Avoid soy milk only ☐ Avoid all soy containing products ☐ Fish ☐ Shellfish ☐ Wheat

List Others: ____

Please identify the food or choice of foods to be substituted: ______________________________
____

**** While the rising prevalence of childhood obesity is a serious health concern, it is <u>NOT</u> currently classified as a disability. Nonetheless, the SISD Child Nutrition Program provides low fat/low sugar/low sodium menus for <u>ALL</u> meals: therefore, a special diet request for these options would not be necessary. Furthermore, in an effort to assist families manage a healthier lifestyle, nutritional information is posted on the SISD Child Nutrition Program website.**

PART II. Disability & *_Life-Threatening Food Allergies_*; additional *supporting medical documentation is required*

<u>DIRECTIONS</u>: Part II to be filled out and completed ONLY by a Licensed Medical Authority treating the student:

- *<u>Part II/Section A & B - If the student has a Disability and/or Life-Threatening Food Allergy</u>*

SECTION A: DISABILITY

Check all disabilities requiring meal modifications:

☐Cerebral Palsy ☐Epilepsy ☐Muscular Dystrophy ☐Nephritis

☐Cancer/Leukemia ☐Orthopedic Impairment ☐Diabetes ☐Drug Addiction/Alcoholism

☐ Hearing Impairment ☐HIV Disease ☐Autism ☐ Other:_________________

☐Traumatic Brain Injury ☐Mental Retardation ☐Emotional Disturbance ___________________________

☐Speech Impairment ☐Visual Impairment ☐ Multiple Sclerosis ___________________________

Major life activity affected by DISABILITY: Note: Sharyland ISD cannot honor this Request Form unless at least one life activity is marked.

☐ Eating ☐ Speaking ☐ Hearing ☐ Seeing ☐ Walking ☐ Learning ☐ Breathing

☐ Caring for One's Self ☐ Performing Manual Tasks ☐ Other, specify: ___________________________

Diet Order: Indicate specific restrictions in space provided

____

Safe Food Substitutes:*

____

☐ **Texture Modification**, if applicable, specify below.

Liquids ☐ No Restrictions ☐ Thin ☐ Thickened (Nectar) ☐ Thickened (Honey) ☐ Thickened (Pudding)

Solids ☐ No Restrictions ☐ Mechanical Soft Chopped ☐ Mechanical Soft Ground ☐ Pureed

*The Child Nutrition Program will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability.

SECTION B: LIFE-THREATENING FOOD ALLERGIES (FOOD ANAPHYLAXIS)

Life-threatening food allergies: ☐ ingestion ☐ contact ☐ inhalation ☐ EpiPen/Emergency Epinephrine prescribed

Eggs: ☐ whole eggs ☐ egg as an <u>ingredient</u>, i.e. scrambled eggs are omitted and egg as an ingredient in pancake is not allowed

Nuts: ☐ peanuts ☐ tree nuts (walnuts, pecans, almonds, hazelnuts…etc.) ☐ sesame seeds

Milk/Dairy allergy: ☐ Avoid all dairy products (fluid milk, cheese, yogurt, ice cream) ☐ Avoid dairy in all baked goods

Soy: ☐ Avoid all soy containing products ☐ Fish ☐ Shellfish ☐ Wheat

List Others: ____

Please identify the food or choice of foods to be substituted: ____

____

Sharyland ISD Child Nutrition Program
1243 E. Business 83
Mission, TX 78572
(956)580-5200 Ext. 1060
childnutrition@sharylandisd.org

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the *USDA Program Discrimination Complaint Form*, (AD-3027) found online at: *http://www.ascr.usda.gov/complaint_filing_cust.html*, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: *program.intake@usda.gov*.