



APPROVED       DENIED

Notes: \_\_\_\_\_  
 \_\_\_\_\_

## 2017-2018 SPECIAL DIET REQUEST FORM

- New** Special Diet Request     
  **Change** Current Special Diet Request     
  **Renew** Existing Special Diet Request     
  **Temporary** Special Diet Request (Start \_\_\_\_\_ & End Date \_\_\_\_\_ )

Student's Full 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)**

**DIRECTIONS:** 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 ingredient, 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 NOT currently classified as a disability. Nonetheless, the SISD Child Nutrition Program provides low fat/low sugar/low sodium menus for ALL 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

**DIRECTIONS:** Part II to be filled out and completed **ONLY** by a Licensed Medical Authority treating the student:

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

**SECTION A: DISABILITY**

Check all disabilities requiring meal modifications:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Cerebral Palsy         | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Muscular Dystrophy    | <input type="checkbox"/> Nephritis                 |
| <input type="checkbox"/> Cancer/Leukemia        | <input type="checkbox"/> Orthopedic Impairment | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Drug Addiction/Alcoholism |
| <input type="checkbox"/> Hearing Impairment     | <input type="checkbox"/> HIV Disease           | <input type="checkbox"/> Autism                | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Mental Retardation    | <input type="checkbox"/> Emotional Disturbance | _____  |
| <input type="checkbox"/> Speech Impairment      | <input type="checkbox"/> Visual Impairment     | <input type="checkbox"/> Multiple Sclerosis    | _____  |

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

- |  |  |  |                                 |                                  |                                   |                                    |
|--|--|--|---------------------------------|----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Eating                | <input type="checkbox"/> Speaking                | <input type="checkbox"/> Hearing               | <input type="checkbox"/> Seeing | <input type="checkbox"/> Walking | <input type="checkbox"/> Learning | <input type="checkbox"/> Breathing |
| <input type="checkbox"/> Caring for One's Self | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Other, specify: _____ |                                 |                                  |                                   |                                    |

Diet Order: Indicate specific restrictions in space provided

Safe Food Substitutes\*:

- Texture Modification**, if applicable, specify below.
- |         |  |  |   |  |   |
|---------|--|--|---|--|---|
| Liquids | <input type="checkbox"/> No Restrictions | <input type="checkbox"/> Thin                    | <input type="checkbox"/> Thickened (Nectar)     | <input type="checkbox"/> Thickened (Honey) | <input type="checkbox"/> Thickened ( pudding) |
| Solids  | <input type="checkbox"/> No Restrictions | <input type="checkbox"/> Mechanical Soft Chopped | <input type="checkbox"/> Mechanical Soft Ground | <input type="checkbox"/> 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 ingredient, 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  
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