Medical Request for Special Dietary Accommodations

Dickinson Independent School District- Food & Nutrition Services
4003 Video Street Dickinson, Texas 77539 • Tel. 281-229-6012

PLEASE RETURN FORM TO THE SCHOOL NURSE

☐ New Order ☐ Change Order ☐ Discontinue Order ☐ No Changes/Continue Order

Student Diet Modification Form- *for cafeteria meals ONLY*

Student Last Name:_____First Name:_____MI:_____Date of Birth:___/___/_____

Student ID#: _____School:_____

Parent/Guardian Contact Information

Name (print):_____Phone Number: _____Email: _____

I give Food & Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to Dickinson ISD.

_____ _____

Parent/Guardian Signature Date

Which meals will the student eat <u>from the school cafeteria?</u> (check all that apply)

☐ Breakfast ☐ Lunch ☐ None (*if student does not eat from the cafeteria, modifications will not be arranged*)

The following MUST be completed by a licensed physician or prescribing medical authority:

Student has a <u>life-threatening/anaphylactic food allergy</u>? ☐ **Yes** ☐ **No**

Section A: Food Allergy (check all foods to be omitted from diet):

☐ **Peanuts** ☐ **Tree Nuts** ☐ **Fish** ☐ **Shellfish**
☐ **Wheat** ☐ **Sesame**

Dairy Allergy (specify): ☐ Fluid Milk Only
☐ All Dairy Including in Baked Goods
☐ Lactose Free (yogurt, cheese, fluid milk)

Egg Allergy (specify): ☐ Whole Plain Eggs (ex: scrambled eggs)
☐ All Eggs Including in Baked Goods

Soy Allergy (specify):
☐ No Soy as a main ingredient (ex. edamame, soy sauce, soy milk)
☐ No Soy as a minor ingredient (ex. soy filler in meats, soybean oil)

Other (please be specific):
_____

Safe Food Substitutes: _____

Section B: Disability

Disability:
_____
_____

<u>Major life activity affected</u> by the disability (check all that apply):

☐ Major Bodily Function ☐ Breathing
☐ Seeing ☐ Speaking ☐ Learning
☐ Eating ☐ Hearing ☐ Walking
☐ Caring for One's Self ☐ Performing Manual Tasks
☐ Other:_____

Texture modification needed?:
☐ Soft (chopped) ☐ Soft (ground)
☐ Pureed ☐ Other:_____

If student must omit MILK or EGGS AS AN INGREDIENT, SOY AS A MINOR INGREDIENT, WHEAT, or HAS MULTIPLE FOOD ALLERGIES, we must provide them with an Allergen Free Meal with very limited options

I certify that the above-named student needs special dietary accommodation, as described above, because of the student's disability or medical condition as indicated.

Name of Licensed Physician (print): _____Physician's Signature: _____
Clinic Name & Address: _____Date:_____Phone:_____

Please allow up to 2 weeks for processing. Questions? Contact Food & Nutrition Services at 281-229-6012

Dickinson ISD FOOD & NUTRITION SERVICES