Child Nutrition Department

Dietary Request Form

FS160 (Revised June 2021)

Student's Legal Name: _____ **Date of Birth:** _____

Student ID: _____ **School Attending:** _____ **Grade:** _____

To Be Completed by Authorized Medical Authority

Reason for Special Diet (Required)

1. Does the student have a medical disability that affects a major life function and requires a meal accommodation? ☐ Yes ☐ No
2. Does the student have a special dietary need that will be helped by a meal accommodation? ☐ Yes ☐ No
3. Describe the condition/diagnosis that requires a special diet or food modification at school

_____

Food Allergy/Intolerance (Check all that apply)

Milk Allergy/Intolerance*: Substitute with: ☐ Lactose Free Milk ☐ Soy Milk

☐ Dairy products (cheese, yogurt, ice cream, etc.) ☐ Milk as an ingredient in all baked goods

Eggs: ☐ Whole eggs ☐ Egg as an ingredient (i.e. baked goods, mayonnaise)

Nuts: ☐ Peanuts ☐ Tree nuts (walnuts, pecans, almonds, hazelnuts…etc.)

Seafood: ☐ Fish ☐ Shellfish

☐ Wheat** ☐ Soy** ☐ Other _____

Suggested Food Substitutions:

*Water and Juice are not reimbursable substitutions for milk.

** Most food items contain wheat and soy. Parent is encouraged to follow-up with Dietitian for menu selections

Therapeutic Diet

(Provide attachments with additional information if necessary)

☐ Gluten Free ☐ Fat Restriction (please provide food list) ☐ Other _____

☐ Diabetic (Please include carb count for each meal below)

_____

Texture Modifications

Solids: ☐ Mechanical Soft (Chopped) ☐ Mechanical Soft (Ground) ☐ Pureed (Applesauce texture)

Liquids: ☐ Thin ☐ Nectar Thick ☐ Honey Thick ☐ Pudding Thick

Special Utensils/Equipment Needed: _____

Nutritional Supplements

Name of Supplement:_____

Specify time (breakfast, lunch, etc.), Quantity, and Mixing instructions (if applicable)

Some substitutions may not be available or allowed. A meeting with the Dietitian may be needed for additional clarification. Verbal requests or emails will not be accepted. Under no circumstances are Child Nutrition Services allowed to revise or change diet prescriptions without written authorization.

Medical Authority (PLEASE PRINT) _____

Medical Authority Signature _____ Date: _____

Address: _____ Phone Number: _____

I understand that menu modifications and/or substitutions will not be made until form is completed and signed by medical authority and parent. Furthermore, if my child's medical or health needs change, it is my responsibility to notify the school office and have the physician complete a new Dietary Request Form

Parent/Guardian Name (PLEASE PRINT) _____

Parent Signature _____ Date: _____

Phone Number _____ Email: _____

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School Nurse/ Personnel USE ONLY

Date received:
Comments:

Scan and Email form to Roxanne.Ruiz@eisd.net Contact Child Nutrition Services at 210-898-4037 with questions or concerns