

2016-2017 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?	
<input type="checkbox"/> Both Breakfast and Lunch <input type="checkbox"/> Breakfast Only <input type="checkbox"/> Lunch Only <input type="checkbox"/> None (If the student does not eat from the cafeteria, no modification will be arranged)	
<i>I understand it is my responsibility to renew this form before each school year and anytime my child's nutritional needs change. I give Edinburg CISD Child Nutrition Department permission to speak with the below-named physician or recognized medical authority to discuss the dietary needs described below.</i>	
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): _____

DIRECTIONS: Part I and Part II 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 or

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

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

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 ECISD Child Nutrition Department 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 ECISD Child Nutrition department website.**

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

SECTION A: DISABILITY

Circle all disabilities requiring meal modifications:

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

Major life activity affected by DISABILITY: Note: Edinburg CISD 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 Department 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: _____

MAIL or FAX To:

Attention: Dietitian
Edinburg CISD Child Nutrition Department
1313 E. Schunior
Edinburg, Texas 78539
Office: (956) 289-2575
Fax: (956) 380-8905