

## 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: _____
<b>Which meals will the student eat from the school cafeteria?</b>	
<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: Dietitians  
Edinburg CISD Child Nutrition Department  
1313 E. Schunior  
Edinburg, Texas 78539  
Office: (956) 289-2575  
Fax: (956) 380-8905