Mansfield ISD Student Nutrition **Special Dietary Request Form**

STUDENT'S NAME _____ **Date of Birth**_____ **ID #**_____

School _____ **Grade**_____

List the child's physical or mental impairment: _____

What must be done to accommodate the child: _____

I. Food Allergy or Intolerance □ **Not Applicable**

Does the child have an Epi Pen at the Campus? □ YES □ NO

□ **Milk Allergy** □ No liquid cow's milk

□ **Dairy Allergy** □ No Yogurt □ No Cheese □ No Sour Cream □ Avoid all dairy products even in baked goods

□ **Egg Allergy** □ No Whole Eggs □ No Egg Whites □ No Eggs in baked goods

□ **No Wheat** □ **No Gluten/Celiac Disease** □ **No Peanut** □ **No Tree Nut** □ **No Fish** □ **No Shellfish**

□ **No Soy Protein/Flour** □ **No Soy Oil/Lecithin** □ **No Corn**

□ **Other (Please list):**_____

Please identify appropriate substitutions for the foods to omit above, if appropriate_____

_____

***Note: The Student Nutrition Dept. will attempt to accommodate the substitution as requested but reserves the right to modify the menu based on product availability.**

II. Texture Modification: □ **Not Applicable**

Liquids:	Solids:
□ Thin (Regular liquids)	□ Mechanical Soft (chopped)
□ Nectar Thick	□ Mechanical Soft (ground)
□ Honey Thick	□ Pureed (Applesauce texture)
□ Pudding Thick	

III. Therapeutic Diet Order: □ **Not Applicable**

Please state therapeutic diet _____

_____

I certify that the above named student needs to be offered food substitutions as described above because of the student's disability/life threatening food allergy or food intolerance/allergy as indicated.

Prescribing Physician/Medical Authority _____

Printed Name of Medical Authority _____**DATE**_____ ☐ **MD** ☐ **DO** ☐ **PA** ☐ **NP** ☐ **SLP**

Name of Practice _____ **Phone Number** _____

I understand that if my child's medical or health needs change, it is my responsibility to alert the student nutrition department of the changes. I also give permission for the department personnel responsible for implementing my child's special diet to discuss my child's special dietary accommodations with my child's medical authority.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

EMAIL CONTACT NUMBER OF PARENT/GUARDIAN

SN Office Use only

Received by: _____ Date: _____

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