

**FOOD AND NUTRITION SERVICES**

**DIET MODIFICATION REQUEST**

**STUDENT’S NAME (LAST, FIRST)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please return form to school nurse upon completion.**

**MISD Dietitian: Rachel Crawford. EMAIL:** **RCrawford@mesquiteisd.org****; PHONE: 972-882-5468. PLEASE CALL WITH QUESTIONS OR CONCERNS.**

***Section* A *or* B *to be completed by authorized medical authority***

**Section A.**

Disability or severe, life threatening food allergy

 Student’s medical condition/disability (**REQUIRED)**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Therapeutic Diet Order:**

Duration:

□ Temporary: Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_End: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Year Round

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□ Diabetic: Carbohydrate Allowance

 Breakfast: \_\_\_\_\_\_\_\_\_g Lunch: \_\_\_\_\_\_\_\_\_\_g Snack: \_\_\_\_\_\_\_\_\_g

□ Cardiac: Fat: \_\_\_\_\_\_\_\_g Na: \_\_\_\_\_\_\_g

□ PKU: Protein: \_\_\_\_\_\_\_g

□ Renal: Na: \_\_\_\_\_\_g K: \_\_\_\_\_\_g Phos:\_\_\_\_\_\_g

□ Sodium Restriction: Na: \_\_\_\_\_\_g

□ Other:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Texture Modification:**

**Medical condition requiring texture modification**

Duration:

□ Temporary: Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Year round

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Liquids: Solids:

□ Thin (Regular liquids) □ Mechanical Soft (chopped)

□ Nectar Thick □ Mechanical Soft (ground)

□ Honey Thick □ Pureed

□ Pudding Thick

1. **Allergies that are life threatening/anaphylactic:**

□ **Yes**, continue with this section □ **No**, refer to section B

Foods to omit from diet:

Allergens:

□ Dairy □ Egg □ Tree Nut □ Soy

□ Corn □ Peanut □ Wheat □ Seafood

□ Other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Substitutions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section B.**

Food Intolerance/Allergy

***Student without a disability but is requesting a special meal or dietary accommodation.***

Student’s allergy/intolerance to food (s) below

***Does not*** result in a ***Life Threatening/Anaphylactic reaction***

1. Food Allergy/Intolerance

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Safe Food Substitutions:

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***Note: Food and Child Nutrition Services will attempt to accommodate the substitution as requested but reserves the right to modify the menu based on product availability**

1. Lactose Intolerance (No liquid milk; other dairy products are allowed)

-Substitutions: (Upon request only)

□ Milk Substitution (Soy milk – offered ONLY at breakfast)

 Note: Water is available to all students at lunch

**Section C.**

Religious Food Restrictions: MISD cannot alter your student’s menu choices based on religion. If you would like a list of menu items containing pork or other food items, please contact the dietitian.

***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.***

**Name of Medical Authority** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□ MD □ DO □ RD □ PA □ NP □ SLP**

 (PLEASE PRINT)

**Prescribing Physician/Medical Authority Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (SIGNATURE) (DATE)

**Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this form will remain on file each year. 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 the school nurse who will then give it the to the district dietitian.

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 PARENT/GUARDIAN SIGNATURE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ADDRESS/EMAIL CONTACT NUMBER OF PARENT/GUARDIAN

**Office Personnel USE ONLY**

Student ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School RN Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School RN Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School RN Contact #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAX FORM TO: 972 882-5580 or EMAIL TO: RCrawford@mesquiteisd.org CONTACT FOOD AND NUTRITION SERVICES DIETITIAN AT 972 882-5468 WITH QUESTIONS OR CONCERNS**

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