Birdville ISD
Child Nutrition Department

SPECIAL DIETARY REQUEST FORM
2024-2025

_____*New* Dietary Request _____*Change/Modify* an Existing Special Diet Request

_____*Renew* Existing Special Diet _____*Temporary* Diet Order (Start Date____/____/____End Date____/____/____)

Part A: ***To be completed by Parent/Guardian***

Student Name (Last, First)		**D.O.B.**
Name of School	**Grade**	**Student ID#**

Part ***To be completed by Medical Authority***

Diagnosis or special dietary condition which restricts diet:

Does the child have a disability? ☐ YES ☐ NO
If yes, describe the major life activities affected by the disability and why the disability restricts the child's diet.

Does the child have special nutritional or feeding needs? ☐ YES ☐ NO
If yes, complete information below:

Does the child have an EPI Pen at the Campus? ☐ YES ☐ NO

Food Allergy or Intolerance:

☐ **Milk Allergy** ☐ No Liquid Cow's Milk

☐ **Dairy Allergy** ☐ No Yogurt ☐ No Cheese ☐ No Sour Cream ☐ Avoid all dairy products even 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 ☐ **Food Allergy NOT APPLICABLE**

☐ **Other (Please List):** _____

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

Texture Modification:

Liquids:	***Solids:***
☐ Thin (Regular Liquids)	☐ Mechanical Soft (chopped)
☐ Nectar Thick	☐ Mechanical Soft (ground)
☐ Honey Thick	☐ Pureed (Applesauce texture)
☐ Pudding Thick	☐ **Modification NOT APPLICABLE**

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

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 Signature X _____

Printed Name of Medical Authority_____Date_____☐ **MD** ☐ **DO** ☐ **PA** ☐ **NP** ☐ **SLP**

Name of Practice_____Phone Number_____

Part C: ***To be completed by Parent/Guardian***

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

This form must be filled out completely BEFORE any dietary modifications can be made.

X _____ _____
Parent/Guardian Signature Date

FAX Completed Form to: 817-547-5552
Birdville ISD, Child Nutrition Department
3120 Carson Street, Haltom City, TX 76117
Telephone: 817-547-5860

_____ _____
Email of Parent/Guardian Telephone Number

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Notification Sent to Manager

*Office Received:*____/____/____ *Received By:* _____ *Date:*____/____/____