Granbury Independent School District
Special Dietary Request Form

Section A: (To be completed by Parent/Guardian)

Student's Name(Last, First):_____

Date of Birth:_____**Grade/Homeroom Teacher:**_____

Student ID#:_____**School:**_____

Which meals will the student eat from the school cafeteria? (Check all that apply)

☐ Breakfast ☐ Lunch ☐ None*(if none, no diet modifications will be made)*

Does the child have a **life-threatening food allergy resulting in an anaphylactic reaction**?

☐ No ☐ Yes(If yes, Physician completes section B)

Has the child been prescribed an **EpiPen**?(Check box)

☐ No ☐ Yes(If yes, please provide to school nurse)

Does the child have a **disability requiring diet modification**?(Check box)

☐ No ☐ Yes(If yes, Physician completes section C)

I understand that if my child's medical or health needs change, it is my responsibility to notify the school nurse/office. I give Child Nutrition Service and/or School Nurse permission to speak with the Physician listed below to discuss the dietary needs described on this form. I understand that any further modifications will require a new form.

Printed Name:_____Date:_____Phone Number:_____

Parent/Guardian Signature:_____Email:_____

Sections B and/or C: To Be Completed Only By a Licensed Physician or Recognized Medical Authority

****Note: Form must be completed in its entirety in order for any diet modifications to be made. Form will be returned if incomplete.**

Section B: Life-Threatening Food Allergy(Check all food that will result in an anaphylactic reaction if consumed):

☐ Eggs ☐ Fish ☐ Peanuts ☐ Milk ☐ All Dairy Products ☐ Shellfish ☐ Soy ☐ Tree Nuts ☐ Wheat ☐ Corn

☐ Liquid Milk Substitution(Required)_____ ☐ Other(Specify)_____

Can the student consume foods where the allergen is an ingredient in a product?

☐ No ☐ Yes *(i.e. Can consume eggs in baked goods, but not scrambled eggs; Can consume soy oil, but not whole soybeans or TVP; etc.)*

Explain:_____

_____

Safe Food Substitutes:_____

Section C: Disability

Disability:_____

Major life activity affected by the disability(Check all that apply):

☐ Breathing ☐ Seeing ☐ Speaking ☐ Performing manual tasks ☐ Learning

☐ Eating ☐ Hearing ☐ Walking ☐ Caring for one's self ☐ Other:_____

Type of Diet: ☐ Regular ☐ Special Mechanical ☐ Chopped ☐ Blended ☐ Pureed ☐ Liquid: Clear ☐ Thickened

Foods to be Omitted:_____

Safe Food Substitutes:_____

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_____**Date**_____

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

Name of Practice_____ **Phone Number**_____