

**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** _____

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