CROWLEY INDEPENDENT SCHOOL DISTRICT

2021-22 DIETARY REQUEST FORM

Student Name:____________________ Date of Birth:__________ ID#:__________

School:____________________ Grade:__________

Section A. (To be completed by authorized medical authority) Disability or severe/life-threatening food allergy

I. Disability or severe life-threatening food allergy

Student has allergies that are life threatening/anaphylactic:

❑ **Yes**, continue with Section A ❑ **No**, refer to Section B

Milk allergy: ❑ No liquid cow's milk (Soy milk offered in place of dairy 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 peanut ❑ No tree nuts ❑ No fish
❑ No shellfish ❑ No soy ❑ No corn ❑ Other:

____

II. Texture Modification:

Liquids:
❑ Thin (regular liquids)
❑ Nectar thick
❑ Honey thick
❑ Pudding thick

Solids:
❑ Mechanical soft (chopped)
❑ Mechanical soft (ground)
❑ Pureed (applesauce texture)

III. Therapeutic Diet Order:

Please state therapeutic diet specifics (Ex. Celiac):

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____

____

Section B. Food allergy/intolerance (NOT LIFE-THREATENING)

Student without a disability or life-threatening food allergy, but is requesting special dietary accommodation.

Lactose intolerance: ❑ Lactaid milk will be provided

Milk allergy: ❑ Soy milk will be offered only for milk allergy

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 peanut ❑ No tree nuts ❑ No fish
❑ No shellfish ❑ No soy ❑ No corn ❑ Other:

____

*Safe food substitutions:

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

Other requests:

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**We cannot guarantee accommodation of all requests.*

Which meals will the student eat from the school cafeteria?
❑ Breakfast ❑ Lunch ❑ Snack ❑ Dinner

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 Practice:____________________ Date:__________

Printed Name of Medical Authority:____________________ ❑ MD ❑ DO ❑ RD ❑ PA ❑ NP ❑ SLP

Prescribing Physician/Medical Authority:____________________ ____________________
SIGNATURE CONTACT PHONE NUMBER

I understand that it is my responsibility to renew this form **before each school year.** I understand that if my child's medical or health needs change, it is my responsibility to provide documentation to the Crowley ISD Child Nutrition office. 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 CONTACT PHONE NUMBER

School Nurse - PLEASE COMPLETE

School RN:__________ Email:__________ Phone:__________

District Dietitian:__________ Email:__________ Phone:__________

Scan and email form to dietitians@crowley.k12.tx.us **Contact Child Nutrition Services Dietitian at 817-297-5940 with questions or concerns.**