

## 2016-2017 MISD Food and Nutrition Services Diet Modification Request

Student's Name (Last, First): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please return form to your school nurse upon completion by an authorized medical authority.

*Please contact your school nurse or the MISD Dietitian with any questions. Phone: 972-882-5468*

### Section A: Medical Conditions Requiring Food Modification

**I. Therapeutic Diet Order**

Duration:

- Temporary: Start: \_\_\_\_\_ End: \_\_\_\_\_  
 Year Round

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: \_\_\_\_\_

**II. Texture Modification**

Duration:

- Temporary: Start: \_\_\_\_\_ End: \_\_\_\_\_  
 Year Round

Liquids:

- Thin (regular liquids)  
 Nectar Thick  
 Honey Thick  
 Pudding Thick

Solids:

- Mechanical Soft (Chopped)  
 Mechanical Soft (Ground)  
 Pureed

### Section B: Allergies/Intolerances

1. Is the Allergy:  Non-life threatening/ mild  Life Threatening (causes severe anaphylaxis)

2. Foods to omit from the diet:

- |  |  |
|--|--|
| <input type="checkbox"/> Seafood<br><input type="checkbox"/> Egg<br><input type="checkbox"/> Tree Nut<br><input type="checkbox"/> Peanut<br><input type="checkbox"/> Soy | <input type="checkbox"/> Fluid cow's milk<br><input type="checkbox"/> All Dairy (yogurt, cheese, etc.)<br><input type="checkbox"/> Corn<br><input type="checkbox"/> Wheat<br><input type="checkbox"/> Other: _____ |
|--|--|

3. **Safe food substitutions:** \_\_\_\_\_

4. Student requires fluid milk substitution (*Note: This does not include other dairy products such as yogurt or cheese unless indicated in the allergy section above*).

- Yes  No

**MISD offers Soy milk as a substitute for fluid milk.**

***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 to the district dietitian.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
ADDRESS/EMAIL

\_\_\_\_\_  
CONTACT NUMBER OF PARENT/GUARDIAN

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