Bryan ISD School Nutrition Services
Dietary Special Request Form 2017-2018

(979) 209-7052
(979) 209-7060 FAX

To Be Completed By Parent or Guardian (Para ser completado por el padre o tutor)

Student Name: _____ Student ID: _____ School: _____
(Nombre del estudiante) (Identificación del Estudiante) (Escuela)

I understand that it is my responsibility to renew this form anytime my child's medical or health needs change or to contact Bryan ISD School Nutrition Services if my child changes campuses. As parent or guardian, I give permission for Bryan ISD to contact the Physician's office regarding my child's dietary needs.

(Entiendo que es mi responsabilidad de renovar este formulario cada vez que cambian las necesidades médicas o salud de mi hijo/hija o ponérse en contacto con Bryan ISD School Nutrition Services si mi hijo/hija cambia de escuelas. Como padre o tutor, le doy permiso para que el Distrito de Bryan se ponga en communicación con la oficina del médico con respecto a las necesidades dietéticas de mi hijo/hija.)

☐ My child will NOT be eating school prepared meals
Mi hijo no se come escolares comidas preparadas

☐ My child WILL be eating school prepared meals
Mi hijo comerá escolares comidas preparadas

Parent/Guardian's Printed Name Padre / Guardián Nombre Impreso	Parent/Guardian's Signature Firma del padre / tutor	Telephone Number Número de teléfono

To Be Completed By Physician's Office

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED (ALLERGY IDENTIFICATION AND SUBSTITUTION) in order for ANY diet modification or substitutions to be made in school meals.

ONLY MARK THOSE FOODS THAT ARE AN ALLERGY FOR THIS PATIENT

Food	Is This A Life Threatening Allergy? (If a food is an allergen but is non-life threatening, mark NO. If the patient is not allergic to this food, leave blank.)	Can the student consume foods where the allergen is an ingredient in the food? (Ex: Scrambled eggs omitted, but eggs as an ingredient allowed?)	Diagnosis and/or Disability (Please list student's diagnosis/disability and how it restricts diet)	Major Life activities affected by the life threatening food allergy or disability (check all that apply):	Substitution (Check the box next to the appropriate substitution request. By signing, the standard food substitutions are accepted unless the other substitutions are written in)
Fluid Milk	**Bryan ISD does not provide milk substitutes.** **Water is available at all cafeterias.**				
Dairy	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**		☐ Breathing ☐ Eating ☐ Seeing ☐ Walking ☐ Speaking ☐ Learning ☐ Caring for one's self ☐ Performing manual tasks ☐ Other: _____	☐ **No Substitution Needed** ☐ **Make Substitution** (Common substitutions: Deli Sandwich w/o cheese, Hamburger) ☐ **Other:** _____

Physician's Printed Name	**Physician's Signature**	**Date**

Clinic/Facility Name	**Telephone**

Food	Is This A Life Threatening Allergy? (If a food is an allergen but is non-life threatening, mark NO. If the patient is not allergic to this food, leave blank.)	Can the student consume foods where the allergen is an ingredient in the food? (Ex: Scrambled eggs omitted, but eggs as an ingredient allowed?)	Diagnosis and/or Disability (Please list student's diagnosis/disability and how it restricts diet)	Major Life activities affected by the life threatening food allergy or disability (check all that apply):	Substitution (Check the box next to the appropriate substitution request. By signing, the standard food substitutions are accepted unless the other substitutions are written in)
Peanut / Tree Nut	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**		☐ Breathing ☐ Eating ☐ Seeing ☐ Walking ☐ Speaking ☐ Learning ☐ Caring for one's self ☐ Performing manual tasks ☐ Other: _____	☐ **No Substitution Needed** ☐ **Make Substitution** (Common substitutions: Fruit, Juice, Nut free Breads/Grains) ☐ **Other:** _____
Fish / Seafood / Shellfish	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**		☐ Breathing ☐ Eating ☐ Seeing ☐ Walking ☐ Speaking ☐ Learning ☐ Caring for one's self ☐ Performing manual tasks ☐ Other: _____	☐ **No Substitution Needed** ☐ **Make Substitution** (Common substitutions: Hamburger, Cheese Sandwich) ☐ **Other:** _____
Soy	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**		☐ Breathing ☐ Eating ☐ Seeing ☐ Walking ☐ Speaking ☐ Learning ☐ Caring for one's self ☐ Performing manual tasks ☐ Other: _____	☐ **No Substitution Needed** ☐ **Make Substitution** (Common substitutions: Baked Chicken) ☐ **Other:** _____
Egg	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**		☐ Breathing ☐ Eating ☐ Seeing ☐ Walking ☐ Speaking ☐ Learning ☐ Caring for one's self ☐ Performing manual tasks ☐ Other: _____	☐ **No Substitution Needed** ☐ **Make Substitution** (Common substitutions: Hamburger, Toast, Cereal, Baked Chicken) ☐ **Other:** _____
Wheat	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**		☐ Breathing ☐ Eating ☐ Seeing ☐ Walking ☐ Speaking ☐ Learning ☐ Caring for one's self ☐ Performing manual tasks ☐ Other: _____	☐ **No Substitution Needed** ☐ **Make Substitution** (Common substitutions: Rice, Rice Pasta, Rice Cereal, Sandwich on Gluten free bread) ☐ **Other:** _____
Other	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**		☐ Breathing ☐ Eating ☐ Seeing ☐ Walking ☐ Speaking ☐ Learning ☐ Caring for one's self ☐ Performing manual tasks ☐ Other: _____	☐ **No Substitution Needed** ☐ **Make Substitution** ☐ **Other:** _____

Please provide additional comments or information as related to diet and / or feeding techniques:

_____

_____

_____ _____ _____

Physician's Printed Name **Physician's Signature** **Date**

_____ _____

Clinic/Facility Name **Telephone**