SEGUIN
Independent School District

2015-2016

SPECIAL DIET REQUEST FORM

Generally, children with food allergies or intolerances do not have a disability as defined under either Section 504 of the Rehabilitation Act or Part B of IDEA. The SNP department is not required to make food substitutions for them.
However, when a license physician's assessment of food allergies result in severe, life threatening reactions of the child, this would meet the definition of "disability" and substitutions prescribed by the physician will be made.

_____

New Special Diet Request _____Change Current Special Diet Request _____
Renew Existing Special Diet Request _____Temporary Request Start ____ & _____
Student's Full Name (please print)
Last: _____ First: _____ Date Requested: _____
Date of Birth: _____ School: _____
Student ID # _____
Parent/Guardian Name (please print): _____
Phone #: _____
Email Address: _____ Mailing Address: _____
City: _____State: _____Zip Code: _____

Meals student will eat in the cafeteria:
Breakfast only: ____Lunch only: _____Breakfast & Lunch: _____

Does the child have identified disability and / or life-threatening food allergy?
No, my child and I will be responsible for self-monitoring the food allergy / intolerance. Complete Part 1-Student has a Non-threatening Food Allergy or Intolerance.
Yes, my child was evaluated in accordance with IDEA as having one or more of the recognized 13 disability categories and who, by reason therefore, needs special education and related services. Complete Part II/Section A & B –Student has a Disability and/or Life Threatening Food Allergy.
I understand it is my responsibility to renew this form before each school year and anytime my child's nutritional needs change. I give Seguin ISD School Nutrition Department permission to speak with the below-named physician or recognized medical authority to discuss the dietary needs described below.

DIRECTIONS: Part I & Part II to be filled out by a Recognized Medical Authority treating the student.

Part I-If the student has a non-life threatening food allergy or intolerance

Part II Section A & B-If the student has a disability and/or life threatening food allergy

Name of Physician (Print) _____

Signature of Physician _____Date _____

Address _____

Part I: Non**-life threatening food allergy or Food Intolerance (check all that apply)**

Eggs: _____

Nuts: Peanuts: _____Tree Nuts: _____Sesame Seeds: _____

Lactose intolerance / Dairy Allergy:

No Milk: _____ Avoid all dairy products: _____

Avoid all dairy in baked products: _____

Fish: _____ Shellfish: ____ Wheat: _____ Corn: _____ Soy: _____ Other: _____

Part II: Disability & Life-Threatening Food Allergies

Section A: Disability

List all disabilities requiring meal modifications:

_____

Major life activity affected by **DISABILITY**: Note: Seguin ISD cannot honor this Request Form unless at least one life activity is marked.

Eating:____ Speaking: ____ Hearing: ____ Seeing: ____ Walking: ____ Learning: ____ Breathing: ____

Caring for One's Self: ____ Performing Manual Tasks: ____Others: _____

Diet Order: Indicate specific restrictions in space provided

Diabetes: _____ NA Restriction: _____ Renal: _____ Texture Modifications, if applicable, specify:

Liquids: No restriction: ___ Thin: ___ Thickened: ___

Solids: No restriction: ___ Soft Chopped: ___ Soft Ground: ___ Pureed: ___

Section B: Life-Threatening Food Allergies (Food Anaphylaxis)

Life threatening food allergies: indigestion: ____contact: ____inhalation:____ Epi-pens prescribed: ____

Eggs: _____

Nuts: Peanuts: _____ Tree Nuts: _____ Sesame Seeds:_____

Lactose intolerance / Dairy Allergy:

No Milk: _____ Avoid all dairy products: _____ Avoid all dairy in baked products: _____

Fish: _____ Shellfish: ____ Wheat: _____ Corn: _____ Soy: _____ Other: _____

Mail or Fax to:

Seguin ISD School Nutrition Department
1105 N. King
Seguin, TX 78155
Fax: 830-379-9326