

Received by nurse: ___/___/___
Received by dietitian: ___/___/___

Bryan ISD School Nutrition Services 2023-2024

DIETARY SPECIAL REQUEST FORM

Student Name: _____ Date of Birth: _____

School: _____ Student ID: _____

Parent/Guardian Contact Information:

Name: _____ Phone Number: _____

Email: _____ Signature: _____

By providing my signature, I understand that I am giving Bryan ISD School Nutrition Services permission to contact the physician's office regarding my child's dietary needs.

Please return this form to the school nurse. Allow up to 2 weeks for processing.

Which meals will the student eat from the school cafeteria?

Breakfast Lunch My child will NOT be eating school meals

*****The following section must be completed by a licensed physician.*****

Section A: Lactose Intolerance	Section C: Disability
<input type="checkbox"/> Lactose Intolerant (NOT dairy allergy) <input type="checkbox"/> No Cheese, No Yogurt <input type="checkbox"/> No Fluid Milk (Choose substitute below): <input type="checkbox"/> Lactose Free Milk <input type="checkbox"/> Soy Milk <input type="checkbox"/> None	Disability: _____ Major life activities affected by the food allergy or disability: <input type="checkbox"/> Breathing <input type="checkbox"/> Eating <input type="checkbox"/> Seeing <input type="checkbox"/> Walking <input type="checkbox"/> Speaking <input type="checkbox"/> Learning <input type="checkbox"/> Caring for one's self <input type="checkbox"/> Performing manual tasks <input type="checkbox"/> Other: _____
Section B: Food Allergy <input type="checkbox"/> Peanuts/Tree Nuts <input type="checkbox"/> Wheat <input type="checkbox"/> Fish/Shellfish <input type="checkbox"/> Sesame <input type="checkbox"/> Soy (Note: will NOT exclude soybean oil unless requested) <input type="checkbox"/> Egg Allergy (please specify below) <input type="checkbox"/> Whole Eggs only (Ex: egg patty, omelet) <input type="checkbox"/> Egg as an ingredient (Ex: baked goods, ranch dressing) <input type="checkbox"/> Dairy Allergy (exclude all products containing dairy, even baked goods) Select milk substitute: <input type="checkbox"/> Soy Milk <input type="checkbox"/> None <input type="checkbox"/> Other Allergy (please be specific): _____ _____	Is a texture modification needed? Solids: <input type="checkbox"/> Regular <input type="checkbox"/> Soft & Bite-Sized <input type="checkbox"/> Minced & Moist <input type="checkbox"/> Pureed Liquids: <input type="checkbox"/> Thin (Regular) <input type="checkbox"/> Slightly Thick (Nectar) <input type="checkbox"/> Mildly Thick (Honey) <input type="checkbox"/> Moderately Thick (pudding)
Are any of these allergies life-threatening? If yes, please list which allergy: _____	

Physician Name: _____ Physician Signature: _____

Clinic Name: _____ Clinic Phone Number: _____ Date: _____

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