

MISD Child Nutrition Department

FOOD ALLERGY/DISABILITY SUBSTITUTION REQUEST FORM

Form is to be completed by an authorized medical professional. Return completed copy to the Child Nutrition Office.

Mailing Address: 510 Heard Street, McKinney, TX 75069 Fax #: 469-302-6310

Information submitted to Health Services at enrollment is NOT received by the Child Nutrition Department. This includes food allergies and intolerances. A completed Food Allergy/Disability Substitution Request Form is the ONLY record the Child Nutrition Department receives and uses to document any special dietary needs.

PART 1: TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name:	Student ID #:	
School:	Grade Level:	DOB:
Parent/Guardian Name:	Relationship to Student:	
Email:	Daytime Phone #:	
Mailing Address:	City:	Zip Code:

Which meal(s) will your student be eating from the school cafeteria? Breakfast Lunch After School Snack

PART 2: MUST BE COMPLETED BY STUDENT'S TREATING PHYSICIAN (PLEASE PRINT)

Does the student have an identified disability, food allergy, or food intolerance requiring a special diet?

If YES: Complete PART 2



If NO: A special diet is not required

- SEVERE ALLERGY:** Student has a food allergy that is severe or causes an anaphylactic reaction
- MILD ALLERGY:** Student has a food allergy that is less severe or does not cause an anaphylactic reaction
- FOOD INTOLERANCE:** Student has a food intolerance that requires a modified diet
- DISABILITY:** Student has a disability that requires a modified diet

Please choose foods to omit from a student's diet during the school day (select all that apply).

Dairy

Eggs

Soy

- | | | |
|---|--|--|
| <input type="checkbox"/> Fluid Dairy Milk | <input type="checkbox"/> Whole Eggs (i.e. scrambled, hard-boiled) | <input type="checkbox"/> Soy protein |
| <input type="checkbox"/> Cheese | <input type="checkbox"/> All menu items with eggs as an ingredient | <input type="checkbox"/> Soybean oil |
| <input type="checkbox"/> Yogurt | | <input type="checkbox"/> All menu items with soy ingredients (incl. soy lecithin, oil) |
| <input type="checkbox"/> ALL Dairy Products | | |
| <input type="checkbox"/> Juice is an acceptable substitute for fluid milk for a milk allergy or intolerance | | |

Nuts

Fish/Shellfish

Wheat/Gluten

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Fish | <input type="checkbox"/> All menu items with wheat as an ingredient |
| <input type="checkbox"/> Tree Nuts | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Celiac |
| <input type="checkbox"/> Other: Please Specify: _____ | | |
| <input type="checkbox"/> Texture Modification: Please Specify (blended, chopped, thickener, etc): _____ | | |

I certify that the above named student requires food substitutes as described above due to their disability, food allergy, or food intolerance.

Medical Authority Name (Printed): _____ Phone Number: _____

Medical Authority Signature: _____ Date: _____

The Child Nutrition Department will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability

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This institution is an equal opportunity provider.

Updated 2/12/2020