



Grand Prairie ISD Special Diet Form



🍏 New 🍏 Change/Modify 🍏 Temporary (End Date: _____)

STUDENT INFORMATION

First Name: _____ Last Name: _____ Today's Date: _____
Student ID Number: _____ Age: _____ Male / Female Date of Birth: ____/____/____
School: _____ Grade: _____ Teacher: _____
Parent/Guardian Name: _____ Phone/Email: _____

MEDICAL INFORMATION

Per the United States Department of Agriculture, a person with a disability is any such person who has an impairment that substantially limits one or more life activities. By definition this includes but is not limited to diabetes, PKU, celiac disease, food anaphylaxis, learning disabilities, and etc.

THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN ONLY.

Patient Diagnosis/Medical Condition: _____
Is patient diagnosis considered a disability? _____ YES _____ NO (DR. INITIAL ONLY)
If yes, please describe major life activities affected in relation to dietary modification: _____

Texture Modification: Ground Chopped Pureed Other (please be specific): _____
Tube Feeding: Formula Name: _____ Instructions: _____ Oral? _____ YES _____ NO
Nutrient Modification: Increase Calories _____ Decrease Calories _____ Nutrient Restriction _____
Omit Foods: _____ Substitute with: _____

Does patient have a life threatening food allergy? _____ YES _____ NO (DR. INITIAL ONLY)

Food Allergies (circle all that apply):

- 🍏 Fluid Milk 🍏 All Dairy Products 🍏 Soy 🍏 Eggs 🍏 All Products With Eggs
- 🍏 Wheat 🍏 Gluten 🍏 Corn 🍏 All Corn Additives 🍏 Seafood
- 🍏 Peanuts 🍏 All Nuts 🍏 All Foods Produced in Facility With Nut Products

Can patient consume allergen as an ingredient in food product? _____ YES _____ NO (DR. INITIAL ONLY)

Administration of Medication at School For Treatment of Allergic Reactions

Allergic Symptoms	Medication	Dosage & Route	Self Carry (DR. INITIAL ONLY)

Physician Name: _____ Phone: (____)____-____

Physician Signature: _____ Date: _____

Any change of treatment must be requested in writing on this form.
Once form is submitted, please allow up to five days for processing. Send completed form to food service department.
By signing below, I understand that it is my responsibility to renew this form anytime my child's medical or health needs change.

Parent Signature: _____ Date: _____