Dear Parent/Guardian,

You have indicated that your child has a food allergy, food allergies or needs other diet modifications. In accordance with Section 5.0 of the Guidance Manual for School Meals, Ruidoso Municipal Schools is requesting a completed Dietary Request Form to be filled out each year from all parents or guardians of enrolling/enrolled students that indicate their child has a food allergy or food allergies.

https://fns-prod.azureedge.net/sites/default/files/cn/SP59-2016os.pdf

Ruidoso Municipal School District is committed to providing a safe and allergy free environment for your child at school.

## This Document is Very Important! Please Read It!

The following steps must be taken in order for the cafeteria to make any changes to your child's meal choices.

1. The Dietary Request Form must be filled out in its entirety by a physician. The doctor must indicate which foods your child cannot consume and what foods may be substituted in place of that item. Cafeteria staff CANNOT substitute or change menu items without written doctor's orders on file. This is federal law.
    a. Diet modifications are strictly followed. For example, if the physician states that your child is allergic to dairy, then cafeteria staff cannot serve pizza, cheese, waffles or any other items that contain dairy to your child – even if you allow your child to consume such items at home. If your child *does not* have a severe allergy, please consider this before submitting the Dietary Request Form.
    b. In order to remove an allergy or diet modification, a second Dietary Request Form must be completed by a physician. It must state that the child is no longer allergic or no longer needs diet modification.
    c. Please note that juice cannot be substituted for milk. This is federal law. Soy milk is available on request.
    d. If you would like to speak to the district Food Service Director before submitting the diet modification form, please see the contact information below.
2. Once the Dietary Request Form has been completed by a physician, please return the form to the Food Services Office.
3. Review the menu with your child so that they understand which choices are available from the cafeteria.

Thank you for your consideration when dealing with food allergies for your child. If you have any questions please do not hesitate to contact the Ruidoso Municipal School Student Nutrition Services Department.

Ruidoso Municipal School Student Nutrition Services
Angie Lane, MBA, MHRM, SNS
lanea@ruidososchools.org

Updated: 7/26/2021
Food Services Director
575-630-7993

# FOOD AND CHILD NUTRITION SERVICES
# DIETARY REQUEST

**2021-2022**

**STUDENT'S NAME (Last, First)**_________________________________**Date of Birth**_________**School**__________________

## Section A. (To be completed by authorized medical authority)

**Disability or severe, life threatening food allergy**
**Student's medical condition/disability (REQUIRED):**

-

### I. Disability or Severe Life Threatening Food Allergy

**Student has allergies that are life threatening/anaphylactic:**

- ☐ **Yes**, continue with this section ☐ **No**, refer to section B
- ☐ **Dairy Allergy:** ☐ No Fluid Dairy Milk ☐ No Yogurt ☐ No Cheese
- ☐ Avoid all dairy products even in baked goods
- ☐ **Milk Allergy** (Soy milk offered in place of dairy milk)
- ☐ **Egg Allergy:** ☐ No Whole Eggs ☐ No Egg Whites ☐ No Eggs in baked goods
- ☐ **No Wheat** ☐ **No Peanut** ☐ **No Tree Nut**
- ☐ **No Fish** ☐ **No Shellfish** ☐ **No Soy** ☐ **No Corn**
- ☐ **Omit foods "processed in a facility" with above √checked ingredients**
- ☐ **Other (Please list):**_____________________________________________

### II. Texture Modification:

☐ Year Round ☐ Temporary: Start:____________Stop:_

| Liquids: | Solids: |
|---|---|
| ☐ Thin (Regular liquids) | ☐ Mechanical Soft (chopped) |
| ☐ Nectar Thick | ☐ Mechanical Soft (ground) |
| ☐ Honey Thick | ☐ Pureed (Applesauce texture) |
| ☐ Pudding Thick | |

### III. Therapeutic Diet Order: (Write specifics in space provided)

- ☐ Diabetic: _____________________________________________
- ☐ Renal: _____________________________________________
- ☐ PKU: _____________________________________________
- ☐ Cardiac: _____________________________________________
- ☐ Sodium Restriction: _____________________________________________
- ☐ Other: _____________________________________________

## Section B.

**Food Allergy/Intolerance (NOT LIFE THREATENING)**
***Student without a disability but is requesting special dietary accommodation***
*** PLEASE √ CHECK either ALLERGY or INTOLERANCE ***

☐ ***ALLERGY*** ☐ ***INTOLERANCE***

**Student's allergy/intolerance to food(s) below:**
***Does not* result in a *Life Threatening/Anaphylactic reaction***

**I.** ☐ **Dairy Allergy:** ☐ No Fluid Dairy Milk ☐ No Yogurt ☐ No Cheese

- ☐ Avoid all dairy products even in baked goods
- ☐ **Lactose Intolerance** (Lactaid Milk will be offered)
- ☐ **Milk Allergy** (Soy milk will be offered only for milk allergy)

**II. Other food allergies/intolerances:**

- ☐ **Egg Allergy:** ☐ **No Whole Eggs** ☐ **No Egg Whites** ☐ **No Eggs in baked goods**
- ☐ **No Wheat** ☐ **No Peanut** ☐ **No Tree Nut**
- ☐ **No Fish** ☐ **No Shellfish** ☐ **No Soy** ☐ **No Corn**
- ☐ **Omit all foods "processed in a facility" with the above √ checked ingredients**
- ☐ **Other (Please list):**_____________________________________________

***Safe Food Substitutions:** _____________________________________________

***Note: Food and Child Nutrition Services will attempt to accommodate the substitution as requested but reserves the right to modify the menu based on product availability**

## Section C.

**Religious/Personal Beliefs Food Restrictions: (Only requires parent/guardian signature)**

☐ **No Pork** ☐ **No Beef** ☐ **No Pork and Beef**

☐ **Other:**_____________________________________________

***I certify that the above named student needs to be offered food substitutions as described above because of the student's disability/Life Threatening food allergy or food intolerance/allergy as indicated.***

**Printed Name of Medical Authority**_________________________________**DATE**____________ ☐ **MD** ☐ **DO** ☐ **RD** ☐ **PA** ☐ **NP** ☐ **SLP**

**Prescribing Physician/Medical Authority:** _________________________________ _________________________
SIGNATURE CONTACT PHONE NUMBER

I understand that it is my responsibility to renew this form **before each school year**. I understand that if my child's medical or health needs change, it is my responsibility to provide documentation from my child's physician to the Food and Child Nutrition Services office and the school nurse.

_________________________________ _________________________
PARENT/GUARDIAN SIGNATURE DATE

_________________________________ _________________________
ADDRESS/EMAIL CONTACT NUMBER OF PARENT/GUARDIAN

**School Nurse/Office Personnel USE ONLY**

Date Parent Contacted________________Date Nurse Contacted________________Date Site Supervisor Contacted________________

Substitutions or modifications:_____________________________________________

**Scan and Email form to:** foodservice@ruidososchools.org **CONTACT FOOD AND CHILD NUTRITION SERVICES DIRECTOR AT 575-630-7993 WITH QUESTIONS OR CONCERNS**

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department.

Revised 7/26/2021