

Knox County Schools

Requirements for Dietary Accommodations

Attached is the Special Dietary Accommodations form designed by Knox County Schools (KCS) Food & Nutrition Services to assist providers in making special dietary requests for children attending Knox County Schools. The form contains a concise way for the RD to receive information needed to approve and send related accommodations information to school cafeterias as quickly as possible. Please send the completed form to the school nurse, who will serve as a liaison between KCS and providers.

Request Requirements on Form

- ◆ Student name, school (may be completed by school nurse) and DOB
- ◆ Whether the request is New, a Renewal with changes, or Renewal/No Change (check appropriate box)
- ◆ Whether or not family intends for the child to eat foods from the cafeteria (check appropriate box)
- ◆ How the condition impacts the child's bodily functions/body systems (check all appropriate boxes on form)
- ◆ Accommodations needed/Foods to be omitted or altered (Check all that apply and list any restrictions not covered by the form under "Other")
- ◆ Foods to be substituted (check appropriate boxes under checked food restriction, list foods for subs under "Other Subs", and/or check box located just above Section C- - - ***"sub with foods free of checked allergens/restrictions"***)
- ◆ Printed name and signature of medical provider, along with checked credentials (check appropriate provider credentials on form)
- ◆ Parent signature, contact information, and date

See form that follows

KNOX COUNTY SCHOOLS FOOD & NUTRITION SERVICES DIETARY REQUEST

School: _____

STUDENT'S NAME (Last, First) _____ Date of Birth _____ ID # _____

ABOUT REQUEST: New Renewal/No Change Revised/with Changes

Family requests food from cafeteria: Yes No

BODY SYSTEMS/FUNCTIONS IMPACTED (Check All That Apply): Bowel Digestive Endocrine Immune Respiratory Other _____

Section A. Food Allergy or Intolerance

Life Threatening Food Allergy: Yes No

Milk/Dairy: ALLERGY INTOLERANCE

Fish: Shellfish: ALLERGY INTOLERANCE

No Fluid Dairy Milk No Yogurt No Cheese

Specify fish type/s, as appropriate _____

Avoid all dairy products & derivatives even in baked goods

Egg Allergy: ALLERGY INTOLERANCE

Dairy baked in foods allowed

Avoid all eggs or derivatives in baked foods

Offer the following milk sub: Lactose Free Sub &/or Soy Milk Sub

Eggs baked in foods allowed

Wheat: ALLERGY WHEAT INTOLERANCE

No Whole Eggs No Egg White

CELIAC DISEASE GLUTEN INTOLERANCE

Corn: ALLERGY INTOLERANCE

Soy: ALLERGY INTOLERANCE (soy oil has been removed from the FDA Allergen labeling requirements due to the removal of protein during processing)

Corn Starch allowed Corn Syrup allowed

Avoid lecithin Lecithin allowed

Avoid all products containing corn & its derivatives even in baked goods (oil excluded)

Avoid all products containing soy & its derivatives even in baked goods (oil excluded)

Other (Please list)

Soy baked in products OK

Other Subs: *Note: Food and Nutrition Services will attempt to accommodate the substitution as requested but reserves the right to modify the menu based on product availability (ATTACH FOOD SUBS LIST, IF NEEDED)

Provide almond milk (available only for simultaneous soy and dairy allergy)

Peanut: Tree Nut: ALLERGY INTOLERANCE

Specify nut type/s, as appropriate _____

Omit foods "processed in a facility" with above vchecked ingredients Sub with foods free of vchecked allergens/restrictions (REQUIRED)

Section B. Texture Modification:

Year Round Temporary: Start: _____ Stop: _____

Liquids:

Level 4 Puree

Level 0 Thin (Regular liquids)

Level 4 Extremely Thick

Level 1 Slightly Thick

Solids

Level 2 Mildly Thick

Level 5 Minced & Moist

Level 3 Moderately Thick

Level 6 Soft & Bite-Sized

Level 3 Liquidized

Level 7 Regular

Section C. Therapeutic Diet Order:

(Write specifics in space provided)

Diabetic: _____

Renal: _____

PKU: _____

Cardiac: _____

Sodium Restriction: _____

Other: _____

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

Printed Name of Approved Medical Authority (see credentials) _____ **DATE** _____ MD DO PA APRN DPM DDS DVM

Check Appropriate Credentials

PROVIDER SIGNATURE _____ **DATE** _____ **CONTACT PHONE NUMBER** _____

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 Nutrition Services office and the school nurse. _____

PARENT/GUARDIAN SIGNATURE

DATE

PARENT/GUARDIAN ADDRESS/EMAIL _____ **CONTACT PHONE NUMBER** _____

School Nurse/Office Personnel USE ONLY

School _____

School RN _____ RN Email _____ Phone # _____

School Caf  Manager _____ Caf  Email _____ Phone # _____

Scan and FAX to School: School nurse will fax form to RD @ 865 594-1203

CONTACT FOOD AND CHILD NUTRITION SERVICES DIETITIAN, Carolyn Perry-Burst at 865 594-3801 WITH QUESTIONS OR CONCERNS

This institution is an equal opportunity provider.

Adapted by Knox County Schools from Denver Independent School District SNP