



## Medical Dietary Accommodation Form

If your student requires a special meal plan related to a medical condition or food allergy, this form must be completed and emailed to DCPS Food and Nutrition Services (FNS) at: [dietary.forms@k12.dc.gov](mailto:dietary.forms@k12.dc.gov). A new form must be submitted each time a dietary change is requested.

Once completed, FNS will contact you to discuss menu options. If you do not have access to email, please submit to the cafeteria manager. **This form requires a Medical Practitioner's signature (licensed physician, physician assistant, or nurse practitioner)**

### Section A- Must be completed by the Parent/Guardian

Name of Student \_\_\_\_\_ Student's Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

School Name \_\_\_\_\_ Student ID \_\_\_\_\_ Teacher's Name \_\_\_\_\_

Does your student typically eat school provided meals?  Yes  No

If yes, which meals provided by FNS will your child eat?

Breakfast  Lunch  Afterschool

In addition, which days will your child most likely eat with FNS?

Monday  Tuesday  Wednesday  Thursday  Friday

**I certify that the above-named student needs special school food as described on this form,**

Parent/Guardian Name (printed) \_\_\_\_\_ Signature \_\_\_\_\_

Phone Number \_\_\_\_\_ Email Address \_\_\_\_\_ Date \_\_\_\_\_

### Section B- Must be completed by the Medical Practitioner (licensed physician, physician's assistant, or nurse practitioner)

Does the student have food allergies? (Note: FNS does not serve products containing Peanuts or Tree Nuts)  Yes  No

If yes, please select the allergen(s) from the list below:

#### Wheat

All Wheat

#### Eggs

- All Egg Proteins- albumin (white) and Yolk
- Whole Egg- hard boiled and scrambled
- Eggs baked in products are ok (i.e. pancakes)

#### Dairy

- All Milk Proteins- Casein, Whey, etc.
- Fluid Milk
- Cheese
- Yogurt

#### Sesame:

All Sesame

#### Tree Nuts (not provided by FNS)

All Tree Nuts

#### Peanuts (not provided by FNS)

All Peanuts

#### Soy

- All Soy Protein
- All Soy Protein, except Soybean Oil

#### Fish

All Fish

#### Shellfish

All Shellfish

**Other:** \_\_\_\_\_

**Specific Foods to Omit or Substitute:**



**Section C- Must be completed by the Medical Practitioner**

Does the student require special modification of dietary textures?  Yes  No

Indicate texture on prescribed special diet.

**Chopped** (please indicate any specific instructions)

\_\_\_\_\_

**Ground** (please indicate any specific instructions)

\_\_\_\_\_

**Pureed** (please indicate any specific instructions)

\_\_\_\_\_

**Section E- Must be completed by the Medical Practitioner**

Does the student have other special nutritional or feeding needs?  Yes  No

Please describe the special diet/feeding needs such as celiac disease, diabetes, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that the above-named student needs special school food as described above,

Medical Practitioner's Name \_\_\_\_\_ Office Phone Number \_\_\_\_\_

Medical Practitioner's Signature \_\_\_\_\_ Date \_\_\_\_\_

**If received by School Staff, please scan and email to: [Dietary.Forms@k12.dc.gov](mailto:Dietary.Forms@k12.dc.gov)**

**For district staff only:**

Dietitian Name: \_\_\_\_\_

Contact date: \_\_\_\_\_