



Medical Dietary Accommodation Form

School Year 2020-2021

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.

Once completed, FNS will contact you to discuss menu options. If you do not have access to email, please submit to the main office.

This form requires a Medical Practitioner's signature.

Section A- Must be completed by the Parent/Guardian

Name of Student _____ Student's ID _____ Grade _____

School Name _____ 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

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 from the list below

Wheat

- All Wheat

Tree Nuts (not provided by FNS)

- All Tree Nuts

Eggs

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

Peanuts (not provided by FNS)

- All Peanuts

Soy

- All Soy Protein
 All Soy Protein, except Soybean Oil

Dairy

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

Fish

- All Fish

Shellfish

- All Shellfish

Other: _____

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 Number _____

Medical Practitioner's Signature _____ Date _____

If received by School Staff, please scan and email to: Dietary.Forms@dc.gov

For district staff only:

Dietitian Name: _____

Contact date: _____