DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Office of Food & Nutrition Services

Parent/Guardian: Please turn in this form to the **nurse** at your child's school. The nurse will then inform school staff and the Office of Food & Nutrition Services (OFNS) of your child's needs.

Nurse: Fax form to (202) 727-2512 or scan to food.dcps@dc.gov

**** OFNS will not honor dietary accommodations forms with incomplete information ****

MEDICAL STATEMENT TO REQUEST DIETARY ACCOMMODATIONS
School Year 2017-2018

1. Name of Student	2. Student ID Number (if known)	3. Date of Birth

4. School	5. Grade/Homeroom

6. Check One:

☐ Student has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

☐ Student does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, or nurse practitioner must sign this form.**

7. Disability or medical condition requiring a special meal or accommodation and explanation of why the disability restricts the Student's diet:

8. If student has a disability, provide a brief description of student's major life activity affected by the disability:

9. Diet prescription and/or accommodation: (*Please describe in detail to ensure proper implementation-use extra pages as needed*)

10. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

11. Foods to be omitted and substitutions: (*Please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed*)

A. Foods To Be Omitted	B. Suggested Substitutions

12. Adaptive Equipment:

13. Afterschool Snack/Supper:

☐ Student participates in afterschool programming where DCPS snack or supper is provided and accommodations are needed.

14. Signature of Parent/Legal Guardian	15. Printed Name	16. Telephone Number	17. Date

18. Signature of Medical Authority*	19. Printed Name	20. Telephone Number	21. Date

*** Physician's signature is required for students with a disability. For students without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.**

INSTRUCTIONS

1. **Name of Student**: Print the name of the student to whom the information pertains.
2. **Student ID Number:** Print the 7 or 8 digit Student ID number (if known).
3. **Date of Birth:** Print the date of birth of the student (mm/dd/yyyy).
4. **School:** Print the name of the school the student is attending this school year.
5. **Grade/Homeroom:** Print the grade and homeroom (teacher name or classroom number) of the student.
6. **Check One:** Check (✓) a box to indicate whether student has a disability or does not have a disability.
7. **Disability or Medical Condition Requiring a Special Meal or Accommodation and explanation of why the disability restricts the student's diet:** Describe the medical condition that requires a special meal or accommodation and why the disability restricts the student's diet (e.g., Type 1 Diabetes, restricts the amount sugar, carbohydrates and sodium included in student's diet).
8. **If Student has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability (e.g., Allergy to peanuts causes a life-threatening reaction).
9. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a nondisabling condition (e.g., All foods must be either in liquid or pureed form. Participant cannot consume any solid foods).
10. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
11. **A. Foods to Be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    B. Suggested Substitutions: List specific foods to include in the diet (e.g., soy milk).
12. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
13. **Afterschool Snack/Supper**: Check (✓) the box to indicate if the student participates in afterschool programming where snack or supper is available and dietary accommodations are needed. If student does not participate, leave blank.
14. **Signature of Parent/Legal Guardian:** Signature of the person requesting the student's medical statement.
15. **Printed Name:** Print name of person requesting the student's medical statement.
16. **Telephone Number:** Telephone number of person requesting the student's medical statement.
17. **Date:** Date person requesting medical statement signed form.
18. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
19. **Printed Name:** Print name of medical authority.
20. **Telephone Number:** Telephone number of medical authority.
21. **Date:** Date medical authority signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.