



## 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). Please submit a new form if a dietary change is requested. Once completed, FNS will contact you to discuss menu options. Please note accommodations are not in place until a start date has been confirmed with a member of the FNS team. If you do not have access to email, please submit this form to the cafeteria manager.

**This form requires a Medical Practitioner's signature (licensed physician, physician assistant, or nurse practitioner)**

### REQUIRED – SECTION A (must be completed by the Parent/Guardian):

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

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

**If your child eats any meals from the cafeteria, which meals do they eat?** We will only provide meal accommodations for the meal periods that you indicate accommodations are needed.

☐ Breakfast ☐ Lunch ☐ Snack or Supper (afterschool programming)

**I certify that the above-named student needs special school food as described on this form. Additionally, I give DCPS Food and Nutrition Services permission to speak with the below named Authorized Medical Authority to discuss the dietary needs described below. I understand that DCPS may discontinue accommodations if I do not respond to communication requests after 3 attempts.**

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

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

### REQUIRED - SECTION B.1 (Must be completed by the Medical Practitioner)

Does the student have food allergies/intolerances that substantially limit the student's ability to eat regular school meals?

☐ **Yes** ☐ **No** (Note: FNS does not currently serve products containing Peanuts or Tree Nuts (incl. Coconut))

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

Wheat:

☐ All Wheat

Eggs:

☐ All Egg Proteins – both whites and yolk

☐ Baked good with eggs allowed (i.e. muffins)

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 Products

☐ All Soy Protein, Soybean Oil allowed

Fish:

☐ All Fish (e.g., tuna, salmon, tilapia)

Shellfish:

☐ All Shellfish (e.g., Shrimp, crab)

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

### Required (If Yes, In Section B.1) - SECTION B.2 (Must be completed by the Medical Practitioner)

**Please inform us of the reaction/s associated with this student's allergy/intolerance:** (For example, "consuming egg or any egg-containing product causes a life-threatening reaction"):



**Required (If Yes, In Section B.1) - SECTION B.3 (Must be completed by the Medical Practitioner)**

Please list the foods to be omitted with suggested substitutions. (For example, "Foods to Omit: gluten-containing products, Substitute with: rice, gluten-free bread").

Foods to Omit:	Substitute with:

**SECTION C (Must be completed by the Medical Practitioner)**

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

If yes, indicate texture on prescribed special diet.

**Solids:**

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

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

**Liquids:**

☐ Thin

☐ Slightly Thick

☐ Mildly Thick

☐ Moderately Thick

☐ Extremely Thick

**SECTION D (Must be completed by the Medical Practitioner)**

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

If yes, please describe the special diet/feeding needs such as 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

Office Name: \_\_\_\_\_ Email: \_\_\_\_\_

*The information in this form may be shared with pertinent DC Public Schools and food-service management vendor staff to properly accommodate your student unless otherwise specified in writing. Accommodations may be discontinued via written request from the parent/guardian.*

**This form should be submitted to: [Dietary.forms@k12.dc.gov](mailto:Dietary.forms@k12.dc.gov)**