DISTRICT OF COLUMBIA
PUBLIC SCHOOLS
Office of Operations

# 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. 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**