# Medical Dietary Accommodation Form

**Student's Name:**

**Date:**

**Parent/Guardian's Name:**

**Address:** 1200 First Street, NE

**City:** Washington, DC 20002

**Phone:** 202.442.5885

**Emergency Contact:**

**Relationship:**

**Medical Practitioner:**

**Phone:** 202.442.5026

**Email:** dcps.dc.gov

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### SECTION A

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

- [ ] Yes
- [ ] No

If Yes, please select the allergen(s)/intolerance(s) from the list below:

- Wheat
- Eggs
- Tree Nuts (not provided by FNS)
- peanuts (not provided by FNS)
- all peanuts (not provided by FNS)
- all egg proteins (not provided by FNS)
- all wheat (not provided by FNS)

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### 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
  - [ ] Wheat
  - [ ] Eggs
  - [ ] Tree Nuts (not provided by FNS)
  - [ ] Peanuts (not provided by FNS)
  - [ ] All Peanuts (not provided by FNS)
- [ ] No

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**Medical Practitioner:**

**Phone:**

**ID:**

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**Parent/Guardian's Signature:**

**Date:**

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**School Name:**

**School Address:**

**School Phone:**

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**Medical Practitioner's Signature:**

**Date:**

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**Institution:**

**Address:**

**Phone:**

**Fax:**

**Email:**

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**Medical Practitioner's Information:**

**License:**

**ID:**

**Practice Location:**

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**District of Columbia Public Schools**

**Office of Operations**

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**Note:** FNS does not currently serve products containing Peanuts or Tree Nuts (incl. Coconut).
### Required (If Yes, In Section B.1) - SECTION B.2

**Must be completed by the Medical Practitioner**

<table>
<thead>
<tr>
<th>Section B.2</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Soy</strong></td>
<td>Soy (हेम/soy):</td>
<td>All Soy Products (हेमौल्के)</td>
</tr>
<tr>
<td><strong>Fish</strong></td>
<td>Fish (हेम):</td>
<td>All Fish (e.g., tuna, salmon, tilapia)</td>
</tr>
<tr>
<td><strong>Shellfish</strong></td>
<td>Shellfish (हेमौल्के):</td>
<td>All Fish (हेमौल्के)</td>
</tr>
</tbody>
</table>

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”) / हल्ला पुष्प या दानुष (हेमौल्के) के साथ हर दिन आनंद के साथ होता है।

<table>
<thead>
<tr>
<th>Food</th>
<th>Substitution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soy Products</td>
<td>Casein, Whey</td>
</tr>
<tr>
<td>Fish</td>
<td>Tuna, Salmon</td>
</tr>
<tr>
<td>Shellfish</td>
<td>Tuna, Salmon</td>
</tr>
</tbody>
</table>

### Required (If Yes, In Section B.1) - SECTION B.3

**Must be completed by the Medical Practitioner**

**Section B.3**

Please list the foods to be omitted with suggested substitutions. (For example, “Foods to Omit: gluten-containing products, Substitute with: rice, gluten-free bread”). / घृतकालिगीत वस्तुएं शिक्षित करता है।

<table>
<thead>
<tr>
<th>Foods to Omit</th>
<th>Substitutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soy Products</td>
<td>Casein, Whey</td>
</tr>
<tr>
<td>Fish</td>
<td>Tuna, Salmon</td>
</tr>
<tr>
<td>Shellfish</td>
<td>Tuna, Salmon</td>
</tr>
</tbody>
</table>

### SECTION C

**Must be completed by the Medical Practitioner**

Does the student require special modification of dietary textures?

<table>
<thead>
<tr>
<th>Yes (हेमौल्के)</th>
<th>No (हेमौल्के)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, indicate texture on prescribed special diet.</td>
<td></td>
</tr>
</tbody>
</table>

**Note:**

- Soy (हेम/soy): All Soy Products (हेमौल्के)
- Fish (हेम): All Fish (e.g., tuna, salmon, tilapia)
- Shellfish (हेमौल्के): All Fish (हेमौल्के)
- Soy Products: Casein, Whey
- Fish: Tuna, Salmon
- Shellfish: Tuna, Salmon
Solids (ሠባር-ነገሮች):

☐ Chopped (please indicate any specific instructions)
  □ Chopped (እባካችሁ፤ ማንኛውንም ሉእየት የሆኑት ብወር ከምቅ)

☐ Ground (please indicate any specific instructions)
  □ Ground (እባካችሁ፤ ማንኛውንም ሉእየት የሆኑት ብወር ከምቅ)

☐ Pureed (please indicate any specific instructions)
  □ Pureed (እባካችሁ፤ ማንኛውንም ሉእየት የሆኑት ብወር ከምቅ)

Liquids (ፈሳሽ-ነገሮች):

☐ Thin (ቀጭን)

☐ Slightly Thick (በመጠናቀቅ-ቀጭን የሆነ)

☐ Mildly Thick (በመካከለኛ-ሁኔታ ወፈር-ያለ)

☐ Moderately Thick (በመካከለኛ-ሁኔታ ወፈር-ያለ)

☐ Extremely Thick (እጅግ-በጣም ወፍራም-የሆነ)

☐ Pureed (please indicate any specific instructions)
  □ Pureed (እባካችሁ፤ ማንኛውንም ሉእየት የሆኑት ብወር ከምቅ)

SECTION D (Must be completed by the Medical Practitioner)

አወቶች (SECTION) D (ስለ ሆና አገልግሎት ወሳኔ ያታወጡ ቅ። ሆ ወላማ ያለው)

If yes, please describe the special diet/feeding needs such as diabetes, etc.

☐ Yes (አዎን)  ☐ No (የለም)

If yes, please describe the special diet/feeding needs such as diabetes, etc. (diabetes)

Medical Practitioner’s Name: ____________________________ Office Phone Number: ____________________________

Medical Practitioner’s Signature: ____________________________ Date: ________/_______/_______

Office Name: ____________________________ Email: ____________________________

Dietary.forms@k12.dc.gov