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 **Nurse@washingtonyuying.org** and **Lunch@washingtonyuying.org**.
If you do not have access to email, please submit to the main office.

A new form must be submitted each time a dietary change is requested or a new food allergy is identified.

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

Section A- Must be completed by the Parent/Guardian

Name of Student _____ Student's Date of Birth _____ Grade_____

Homerooom Animal _____ Teacher's Name _____

Does your student plan to eat school provided meals? ☐ Yes ☐ No

If yes, which school provided meals would your student be eating?

☐ Breakfast ☐ Lunch ☐ Afterschool Snack (REEF) ☐ Classroom Snack (Grades PreK 3 -1st Grades)

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 (licensed physician, physician's assistant, or nurse practitioner).

Does the Student have food allergies? ☐ Yes ☐ No

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

Wheat

☐ All Wheat

Eggs

☐ All Egg Proteins - Albumin (white) and yolk

☐ Whole Egg - Hard Boiled and scrambled

☐ Eggs baked in products are okay

(i.e. pancakes, french toast, crackers, muffins, etc..)

Dairy

☐ All Milk proteins - Casein, Whey, etc...

☐ Fluid Milk

☐ Cheese

☐ Yogurt

Sesame

☐ All Sesame

Peanuts (not provided by school)

☐ All Peanuts

Tree Nuts (not provided by school)

☐ All Tree Nuts

Fish

☐ All Fish

Shellfish

☐ All Shellfish

Soy

☐ All Soy

☐ All Soy, except Soybean oil

G6PD

☐ Just Fava Beans

☐ All Beans

☐ All Legumes

☐ All Soy

☐ All Soy, except Soybean oil

Other G6PD Specific_____

_____

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)

_____

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

_____

Section D- 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 as celiac, diabetes, etc..

_____

_____

_____

_____

I certify that the above-named student needs special school food as described above,

Medical Practioner's Name (printed)_____ Office Phone _____

Medical Practioner's Signature _____ Date_____

In school use only:

Date received: _____

Date Processed by Meal Operations: _____

Date info submitted to Food Vendor, if applicable: _____

Date system updates completed by MO: _____

This institution is an equal opportunity provider.