Nurse: Scan and send *completed* forms to schoolfood@dccentralkitchen.org

Dietary Accommodation Request Form SY 2024-2025

Use this form to alert DC Central Kitchen (DCCK) of the dietary accommodations your student needs for the school year. This form is not intended to accommodate student taste preferences. **Please submit this completed form to your student's school nurse**. You will be contacted via email when meals reflecting your student's dietary accommodation will be available in the cafeteria.

A. Student Information.

First Name:	Last Name:	Date of Birth:
School Year 2024/2025 School Name:		Student ID:

Grade Level for School Year 2024/2025: *(check only one)*

☐ Pre-K3 ☐ Pre-K4 ☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐ Adult Education

B. Student's Dietary Accommodations. *Check all that apply.*

☐ **A. Milk Substitution**: The student is requesting a milk substitute due to a medical or other special dietary need. DCCK has the discretion to select a specific brand of milk substitute, provided it meets specified USDA nutrient requirements. Juice cannot be offered as a milk substitute. DCCK serves only nut-free items, so nut milks are not available.

☐ **B. Philosophical Accommodation:** The student is requesting dietary accommodations for philosophical reasons, such as following a plant based diet. **Dietary instructions, including list of foods to be omitted:** _____

_____

☐ **C. Food Intolerance/Medical Accommodation:** The student is requesting a dietary accommodation due to food intolerance(s) or other medical reasons. Please be advised that all DCCK foods are nut-free items. ***A medical practitioner must complete the section below.***

Completed by Medical Practitioner for Option C

What is the student's medical condition and why does it restrict their diet? *(e.g. Type 1 Diabetes; allergy to wheat or fish.)*

_____

_____

_____

Food texture required: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Is the food allergy airborne? ☐ Yes ☐ No

Foods to omit:	Suggested Substitutions:

Medical Office Stamp

Medical Practitioner Name: _____

Medical Practitioner Signature: _____

Date: _____ **Medical Practitioner ID:** _____

C. Parent/Caretaker Signature

I confirm all the information provided above is correct to the best of my knowledge. I understand that the information on this form will remain in effect until the end of the school year for which it is received. When necessary throughout the school year, I will update this form to reflect changes in my student's medical and/or nutritional needs. I understand that DCCK may have discretion as to whether it is able to accommodate these requests.

Printed Name: _____ **Signature**: _____ **Date**: _____

Phone: _____ **Email:** _____