

## Dietary Accommodation Request Form SY 26-27

Use this form to alert Cedar Tree Academy 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 Cedar Tree Academy's school nurse.**

### A. Student Information.

<b>First Name:</b>	<b>Last Name:</b>	<b>Date of Birth:</b>
<b>School Year 2026/2027 School Name:</b>		<b>Student ID:</b>
<b>Grade Level for School Year 2026/2027:</b> (check only one)	<input type="checkbox"/> Pre-K3 <input type="checkbox"/> Pre-K4 <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> 4 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup>	

### 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. CTA 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. CTA serves only nut-free items, so nut milk is not available.
- B. Philosophical Accommodation:** The student is requesting dietary accommodation 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 dietary accommodation due to food intolerance(s) or other medical reasons. Please be advised that all 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 CTA may have discretion as to whether it is able to accommodate these requests.

**Printed Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_