CAPITAL CITY
PUBLIC CHARTER SCHOOL

MEDICAL STATEMENT TO REQUEST DIETARY ACCOMMODATIONS

Name of Student		**Student Date of Birth**
Name of Parent or Guardian	**Parent Email**	**Parent Phone Number**

Check one:

☐ Student has food anaphylaxis (life-threatening food allergy). Parents must submit the DC Universal Health Form stating this.

☐ Student does not have food anaphylaxis (life-threatening food allergy), but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. A licensed physician, physician's assistant, or nurse practitioner must sign this form.

List Food Intolerance:

_____

List Significant Food Allergies:

_____ _____

_____ _____

_____ _____

***Signature of Licensed Healthcare Practitioner**	**Printed Name**	**Phone Number**	**Date**

*For this purpose, a licensed healthcare practitioner is a licensed physician, a physician assistant, or a nurse practitioner.
The information on this form should be updated yearly to reflect the current nutritional needs of the student.