



MEDICAL STATEMENT TO REQUEST DIETARY ACCOMMODATIONS

Name of Student		Student Date of Birth	
Name of Parent or Guardian	Parent Email	Parent Phone Number	
<p>Check one:</p> <p><input type="checkbox"/> Student has food anaphylaxis (life-threatening food allergy). Parents must submit the DC Universal Health Form stating this.</p> <p><input type="checkbox"/> 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.</p>			
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.

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