Medical Dietary Accommodation Form  
School Year 2022 - 2023

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

### Section A - Must be completed by the Parent/Guardian

<table>
<thead>
<tr>
<th>Name of Student</th>
<th>Student’s Date of Birth</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeroom Name</td>
<td>Teacher’s Name</td>
<td></td>
</tr>
</tbody>
</table>

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,

<table>
<thead>
<tr>
<th>Parent/Guardian Name (printed)</th>
<th>Signature</th>
<th>Phone Number</th>
<th>Email Address</th>
<th>Date</th>
</tr>
</thead>
</table>

### 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 ok (i.e. pancakes, crackers, muffins etc.)

- **Dairy**
  - ☐ All Milk Proteins- Casein, Whey, etc.
  - ☐ Fluid Milk
  - ☐ Cheese
  - ☐ Yogurt

- **Peanuts (not provided by school)**
  - ☐ All Peanuts

- **Tree Nuts (not provided by school)**
  - ☐ All Tree Nuts

- **Soy**
  - ☐ All Soy Protein
  - ☐ All Soy Protein, except Soybean Oil

- **Fish**
  - ☐ All Fish

- **Shellfish**
  - ☐ All Shellfish

- **G6PD**
  - ☐ All Beans
  - ☐ All Legumes
  - ☐ All Soy
  - ☐ All Soy, except Soybean oil

Specific Foods to Omit or Substitute:

- ___________________________________________________________
- ___________________________________________________________
- ___________________________________________________________

Other G6PD Specific: ___________________________________________

Rev 8/22
### 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 such as celiac, diabetes, etc.

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

Medical Practitioner’s Name (printed) ____________________________ Office Phone ________________

Medical Practitioner’s Signature ____________________________ Date ________________

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**In school use only:**

Date received by Nurse: ________________

Date processed by Meal Operations: ________________

Date system updates completed by MO: ________________

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This institution is an equal opportunity provider.