School-Based Child Nutrition Programs
PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

CHILD'S NAME	AGE	DATE
PARENT'S/GUARDIAN'S NAME and PHONE NUMBER		
CHILD'S SCHOOL		

Dear Parent/Guardian:

This school participates in a federally-funded School-Based Child Nutrition Program and must serve meals, including milk, that meet program requirements. Reasonable food accommodations must be made when the accommodation being requested is due to a disability or allergy supported by a physician's statement. Reasonable food accommodations may be made for children without disabilities or allergies who may still have special dietary needs; a medical statement is still required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form. Return form to the address below or to your child's school cafeteria. If you have any questions, please contact me at 351-3852.

Sincerely,

Mary Davis, Director of Food Services
1103 N. Neil
Champaign, IL 61820

PHYSICIAN STATEMENT

1. *Does child have a disability that requires food accommodation? (Does he/she have a "physical or mental impairment which substantially limits one or more major life activities"?)*

   ☐ **No**   **If no, go to item 2. Below.**

   ☐ **Yes**   **If yes, provide the following information and complete items 3, 4, and 5 below.**

   a. **What is the disability?**   _____

   b. **What major life activity is affected?**   _____

   c. **How does the disability restrict the diet?** _____

2. *Child has no disability but requires a special diet. Identify medical problem/allergy which restricts the child's diet and complete items 3, 4, and 5 below.*

3. *List food/type of food to be omitted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.*

Continues on other side - - -

4. *List food/type of food to be substituted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached. Continue on next page if necessary.*

5. _____

_____
           Date   **Signature of Physician**

_____
                                           Physician's Phone Number

---

FOR SCHOOL USE ONLY:

☐ Form received on _____.

☐ Form complete and accommodations will begin on _____.

☐ Form incomplete. Parent contacted on _____.

_____   _____ ____
               Date   Signature of Director of Food Service/Representative