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

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<tr>
<th>CHILD’S NAME</th>
<th>AGE</th>
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<tr>
<th>PARENT’S/GUARDIAN’S NAME and PHONE NUMBER</th>
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<th>CHILD’S SCHOOL</th>
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**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