SAMPLE FORMAT: Format may be modified and/or copied to meet specific School-Based Child Nutrition Programs record keeping needs. Do not return to Illinois State Board of Education.

School-Based Child Nutrition Programs
PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

CHILD'S NAME	AGE	DATE

Dear Parent/Guardian:

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

Sincerely,

_____
Food Service Director/Contact

_____
School Name

_____
Address (Street)

_____
Address (City, State, Zip Code)

PHYSICIAN STATEMENT

1. Does child have a disability according to 7 CFR Part 15b 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 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.

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.

5. _____ _____
   Date *Signature of Physician*

FOR SCHOOL USE ONLY:

☐ Form received on _____.

☐ Form complete and accommodations will begin on _____.

☐ Form complete, but accommodation will not be made. ☐ Child does not have a disability ☐ Request not reasonable

☐ Form incomplete. Parent contacted on _____.

_____ _____
Date Signature of Food Service Director/Contact