4C: Community Coordinated Child Care
155 North Third Street, Suite 300
DeKalb, Illinois 60115
(815) 758-8149 or (800) 848-8727
Fax: (815) 758-5652
www.four-c.org

Child Nutrition Programs
PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

CHILD'S NAME	AGE	DATE
SCHOOL/FACILITY NAME	ADDRESS (Street, City, State, Zip Code)	

Parent/Guardian:

This school/facility participates in a federally-funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable food accommodations must be made when the accommodation 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 _____ (*Name*) at _____ (*Telephone (Include Area Code)*).

PHYSICIAN STATEMENT

1. Does child have a disability according to 7 CFR Part 15d 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 OFFICE USE ONLY:
- ☐ Form received on _____.
- ☐ Form incomplete. Parent contacted on _____.
- ☐ Form complete. Accommodation will not be made. ☐ Child does not have a disability ☐ Request not reasonable
- ☐ Form complete. Accommodations will begin on _____.

_____ (*Date*) _____ (*Signature of Food Service Director/Contact*)