Child Nutrition Programs

PHYSICIAN STATEMENT FOR MEAL ACCOMMODATIONS

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 meal accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable meal 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 ______________________________________________ at ________________________________. Name

Telephone (Include Area Code)

PHYSICIAN STATEMENT

1. Is this accommodation being requested on the basis of a:
   □ preference
   □ mental or physical impairment or disability according to ADA Amendments of 2008?
     List the impairment or disability: ________________________________

2. How does this physical or mental impairment restrict the child's diet?

3. What accommodations are being requested? For the safety of the child and because most school/child care centers do not have access to a registered dietician, please be as specific as possible. Attach additional sheet if needed.
   □ Timing of meal service: ________________________________
   □ Alteration of meal preparation method: ________________________________
   □ Variation from meal pattern (must include foods to be omitted as well as foods to be substituted; you may attach a menu). ________________________________

4. _______ Date __________________________ Signature of Physician __________________________ Printed Name

5. _______ Date __________________________ Signature of Parent/Guardian __________________________ Printed Name

FOR SCHOOL/FACILITY 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 __________________________ Printed Name

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