Child Nutrition Programs

PHYSICIAN STATEMENT FOR MEAL ACCOMMODATIONS

<table>
<thead>
<tr>
<th>CHILD'S NAME</th>
<th>AGE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SCHOOL/FACILITY NAME</th>
<th>ADDRESS (Street, City, State, Zip Code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 __________________________

Telephone (Include Area Code)

Name

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 __________________________.
[ ] Request not reasonable
[ ] Form incomplete. Parent contacted on __________________________.
[ ] Form complete. Accommodation will not be made. [ ] Child does not have a disability
[ ] Form complete. Accommodations will begin on __________________________.

Signature of Food Service Director/Contact __________________________ Printed Name

ISBE 67-48 (5/17)