

Friendship House  
100 S Main St Suite 400  
Crystal Lake, IL 60014

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 \_\_\_\_\_ at \_\_\_\_\_  
*Telephone (Include Area Code)* *Name*

**PHYSICIAN STATEMENT**

- 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.**
  - What is the disability? \_\_\_\_\_
  - What major life activity is affected? \_\_\_\_\_
  - How does the disability restrict the diet? \_\_\_\_\_
- 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.
- 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.
- 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.
- \_\_\_\_\_ *Date* \_\_\_\_\_ *Signature of Physician*

<b>FOR OFFICE USE ONLY:</b>	
<input type="checkbox"/> Form received on _____.	
<input type="checkbox"/> Form incomplete. Parent contacted on _____.	
<input type="checkbox"/> Form complete. Accommodation will not be made. <input type="checkbox"/> Child does not have a disability <input type="checkbox"/> Request not reasonable	
<input type="checkbox"/> Form complete. Accommodations will begin on _____.	
_____ <i>Date</i>	_____ <i>Signature of Food Service Director/Contact</i>