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*