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.**

   ☐ Anaphylactic reaction to:_____ ☐ Epipen

   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*

6. _____ _____
   Date *Signature of Parent/Guardian*

FOR SCHOOL 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