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CALHOUN COMMUNITY UNIT DISTRICT 40

Hardin, Illinois 62047
"Home of the Warriors"

School-Based Child Nutrition Programs
PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

CHILD'S NAME	AGE	DATE

Dear Parent/Guardian:

This school participates in a federally-funded School-Based Child Nutrition Program and must serve meals and/or milk meeting program requirements. Reasonable food accommodations must be made when the accommodation being 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 me at _____.
School Phone Number

Sincerely,

_____
Food Service Director/Contact

_____
School Name

_____
Address (Street)

_____
Address (City, State, Zip Code)

PHYSICIAN STATEMENT

1. Does child have a disability according to 7 CFR Part 15b 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 SCHOOL USE ONLY:
- ☐ Form received on _____.
- ☐ Form complete and accommodations will begin on _____.
- ☐ Form complete, but accommodation will not be made. ☐ Child does not have a disability ☐ Request not reasonable
- ☐ Form incomplete. Parent contacted on _____.

_____ _____
Date Signature of Food Service Director/Contact