Child Nutrition Programs

PHYSICIAN STATEMENT FOR MEAL ACCOMMODATIONS

<table>
<thead>
<tr>
<th>CHILD’S NAME</th>
<th>AGE</th>
<th>DATE</th>
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<tr>
<th>SCHOOL/FACILITY NAME</th>
<th>ADDRESS (Street, City, State, Zip Code)</th>
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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 Elena Hildreth at 847-888-5000 x5036.

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?

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

Date
Signature of Food Service Director/Contact
Printed Name