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 **Dana Colla** at **847-888-5000 x5034**.

**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?
   
   List the impairment or disability: __________________________________________
   __________________________________________

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  [ ] Request not reasonable
- [ ] Form complete. Accommodations will begin on ____________________________.

_______________________________  _________________________________  __________________________________
Date  Signature of Food Service Director/Contact  Printed Name

ISBE 67-48 (5/17)