Child Nutrition Programs PHYSICIAN STATEMENT FOR MEAL ACCOMMODATIONS

CHILD'S NAME	AGE	DATE
SCHOOL/FACILITY NAME	ADDRESS (Street, City, State, Zip Code)	

Parent/Guardian:

at

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 Name

Telephone (Include Area Code)

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?
- 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. 3.
 - □ 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
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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