Insert Sponsor Name

Child Nutrition Programs
PHYSICIAN STATEMENT FOR MEAL ACCOMMODATIONS

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 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* at _____ *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?

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*