

**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 \_\_\_\_\_  
at \_\_\_\_\_ *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?
  
  
  
  
  
  
  
  
  
  
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:**

<input type="checkbox"/> Form received on _____.		
<input type="checkbox"/> Form incomplete. Parent contacted on _____.		
<input type="checkbox"/> Form complete. Accommodation will not be made. <input type="checkbox"/> Child does not have a disability <input type="checkbox"/> Request not reasonable		
<input type="checkbox"/> Form complete. Accommodations will begin on _____.		
_____	_____	_____
<i>Date</i>	<i>Signature of Food Service Director/Contact</i>	<i>Printed Name</i>