



Child Nutrition Programs
PHYSICIAN STATEMENT FOR MEAL ACCOMMODATIONS

Form with fields for CHILD'S NAME, AGE, DATE, SCHOOL/FACILITY NAME, and 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.

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.
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, Form complete. Accommodations will begin on, Child does not have a disability, Request not reasonable, Date, Signature of Food Service Director/Contact, Printed Name