



Bloomington Public Schools—District 87
Physician Statement for Food Substitution

Child's Name:	School/Grade:	Date:
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Dear Parent/Guardian:

This school participates in a federally-funded School-Based Child Nutrition Program and must serve meals and/or milk meeting program requirements. Reasonable food accommodations must be made when the accommodation being requested is due to a disability and may be made for children without disabilities who have special medical dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your licensed physician to complete and sign this form. If you have any questions, please contact me at **309-827-6031 ext 229**.

Sincerely,

Julie McCoy MS, RD, LDN
School Nutrition Director
300 E. Monroe
Bloomington, IL 61701

I consent to the sharing of relevant medical information between the school, physician's office, and necessary District 87 staff.

Parent/Guardian Name:	Signature:	Phone:
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Physician Statement

1. Does child have a disability that requires food accommodation?
 - No ____ If no, go to item 2 below.
 - Yes ____ If yes, provide the following information and complete items 3-5 below.
 - a) What is the disability? _____
 - b) What major life activity is affected? _____
 - c) How does the disability restrict the diet? _____

2. Child has no disability, but requires a special diet. Identify the medical problem which restricts the child's diet and complete item 3-5 below.

3. List food/type of food to be **OMITTED**. For the safety of the child, please be as specific as possible.

4. List food/type of food that should be **SUBSTITUTED** for those foods omitted above. For the safety of the child, please be as specific as possible.

5. Is this condition life-threatening?
 - a. No _____
 - b. Yes _____ if yes, the district will convene a meeting to consider a 504 Plan or Health Plan.

6. _____

Date
Signature of Physician

For School Use Only:

- Form received on _____ Letter sent to parent on: _____ Parent called on: _____
- Form complete and accommodations will begin on _____.
- Form complete, but accommodations will not be made per parent request.
- Form incomplete. Parent contacted on _____.

Date: _____ **Signature of School Nutrition Director/Contact:** _____