



**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 1023**.

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.*

<b>Parent/Guardian Name:</b>	<b>Signature:</b>	<b>Phone:</b>
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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:** \_\_\_\_\_