Bloomington Public Schools—District 87

Physician Statement for Food Substitution

Child's Name:	School/Grade:	Date:

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.

Parent/Guardian Name: **Signature:** **Phone:**

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: _____**