HEALTHCARE PROVIDER STATEMENT
FOR FOOD SUBSTITUTION

This form must be completed if a parent/student is requesting menu substitutions be made in the dining center for a student’s food allergy or intolerance

CHILD’S NAME:  DATE:

Dear Parent/Guardian:

Your child’s school participates in a federally-funded School-Based Child Nutrition Program that requires CPS to offer meals and/or milk to students. However, when a disability (for example, a food allergy) or special dietary need or restriction documented by a healthcare provider exists, reasonable menu accommodations must be made. Please provide your contact information and ask your child’s healthcare provider to complete this form. Please return the completed form to your child’s School Nurse along with a Food Allergy Action Plan (found at cps.edu/OSHW). Contact food@cps.edu with any additional questions:

____________________________________________________________________
____________________________________________________________________

Healthcare providers’ note: Food allergies are a “disability” under the Americans with Disabilities Act. If the child has a food allergy, please check “Yes” for question 1 below.

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 follow information and complete items 3, 4, and 5
   a) What is the disability? ____________________________
   b) What major life activity is affected? ____________________________
   c) What does the disability mean for the child’s diet? ____________________________

2. Child has no disability, but requires a special diet. Identify the medical problem that warrants the child’s special diet and complete item 3, 4, & 5 below.

3. List specific foods to be omitted:

4. List specific acceptable food substitutions. Please attach a menu if applicable:

5. __________________________________________________________________________

   Signature of Health Care Provider  Date

   Parent/Guardian: Return this form to your School Nurse

FOR SCHOOL USE ONLY: Please scan and email this form to food@cps.edu.

School Nurse Signature: _____________________________________________
Date reviewed: _____________________________________________
Date scanned to food@cps.edu: _____________________________________________