



# Healthcare Provider Statement For Food Substitution



This form must be completed if a parent/student is requesting menu substitutions be made in the lunch room for a student's food allergy or intolerance.

Does your child eat school meals?  YES  NO

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](http://cps.edu/OSHW)). Contact [food@cps.edu](mailto:food@cps.edu) with any additional questions.

please print or type:

STUDENT LAST NAME	STUDENT FIRST NAME	STUDENT MIDDLE NAME	
PARENT/GUARDIAN NAME	PARENT/GUARDIAN EMAIL		
PARENT/GUARDIAN PHONE	SCHOOL NAME		
SCHOOL ADDRESS	CITY	STATE	ZIP

## 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.

1. DOES CHILD HAVE A DISABILITY THAT REQUIRES FOOD ACCOMMODATION? <input type="checkbox"/> NO If NO, go to item 2 to the right. <input type="checkbox"/> YES If YES, provide the below information and complete items 3, 4, and 5 to the right.	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.
a) What is the disability?	3. LIST SPECIFIC FOODS TO BE OMITTED:
b) What major life activity is affected?	4. LIST SPECIFIC ACCEPTABLE FOOD SUBSTITUTIONS. PLEASE ATTACH A MENU IF APPLICABLE:
c) What does the disability mean for the child's diet?	5. SIGNATURE OF HEALTH CARE PROVIDER. <span style="float: right;">DATE</span>

SCHOOL USE ONLY: Please give a copy of this form to the school nurse and the lunchroom manager. Also scan and email the form to [food@cps.edu](mailto:food@cps.edu).

School Nurse Signature

Date reviewed

Date scanned to [food@cps.edu](mailto:food@cps.edu)