Food Service Department | 217-351-3852
806 Pioneer St. Champaign, IL 61821 | Champaign Unit 4 School District

PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION FORM

Dear Parent/Guardian:

Champaign Unit 4 School District participates in a USDA federally-funded 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 supported by a Physician's Statement. Reasonable meal accommodations **may** be made for children without disabilities who may still have special dietary needs; a medical statement is required. If you are requesting a meal accommodation or substitution, please ask your licensed physician to complete and sign this form. **This form must be completed annually for any menu modification request**. If you have any questions, please contact your school nurse or Lead/Café Coordinator at the school your student attends**.**

Sincerely,

Champaign Unit 4 Food Service Department

Please return completed and signed form to Food Service at foodservice@u4sd.org or 806 Pioneer Street Champaign, Illinois 61820.

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student (Last, First): _____Grade:_____

School: _____

Parent/Guardian Email: _____ Daytime Phone: _____

Based on information listed below my child will require a menu modification at the following: ☐ Breakfast ☐ Lunch ☐ Afterschool Snack

☐ Supper ☐ Other _____

IF MILK IS BEING OMITTED: Will the student drink a USDA-approved fluid milk substitute, such as soy milk, if offered? ☐ Yes ☐ No

I understand it is my responsibility to renew this form each school year and/ or any time my child's medical or health needs change.
I consent to the sharing of relevant medical information between the school, physician's office, and necessary Champaign Unit 4 staff.

_____ _____ _____

Parent/Guardian Name PRINTED | Parent/Guardian SIGNATURE | Date

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Physician Statement

1. Is this accommodation being requested on the basis of a:

   ☐ Mental or Physical impairment or disability according to ADA Amendments of 2008

   List the disability or impairment: _____

   ☐ Preference

   ☐ Other

   Specify: _____

2. How does this physical or mental impairment restrict the student's diet?

3. For the safety of the child, we require a parent or a guardian to review the school menu with the student's licensed physician or school nurse. The menu and nutrition information can be found at https://champaignschoolsfoodservices.org/ under ***Menus***. An interactive filter that includes the top 8 food allergens can be found under ***Special Meal Accommodations***.

TO BE COMPLETED BY MEDICAL AUTHORITY (Licensed by State of Illinois to prescribe medication)

The Dietary Needs below are related to (ex: Celiac Disease, Lactose Intolerance, Diabetes, Anaphylactic Food Allergy)

Food To BE OMITTED from diet* (check appropriate boxes below)

- ☐ **Dairy** – Fluid milk, cheese, yogurt, and other dairy ingredients such as casein and whey.
- ☐ **Fluid Milk** – Milk to drink
- ☐ **Peanuts** – Peanuts, Peanut Butter, Peanut oil.
- ☐ **Tree Nuts** – Almonds, hazelnuts, and cashews.
- ☐ **Wheat** – Wheat-based grains such as buns, crackers, pasta, and wheat as an ingredient.
- ☐ **Gluten** – Wheat, rye, barley, and non-certified oats.
- ☐ **Fish** – Fin-fish such as cod and tilapia
- ☐ **Shellfish** – Shrimp and crab
- ☐ **Egg** – Visible egg in a dish such as an omelet
- ☐ **Egg Ingredients** – Egg white, egg yolk or whole egg as an ingredient
- ☐ **Soybean** – Textured Soy Protein, Textured Vegetable Protein, tofu, and whole soybeans (edamame).
- ☐ **Soybean Ingredients** – Soy protein concentrate, soy protein isolate, soy sauce, soy flour, and unrefined soy bean oil
- ☐ **Other** - _____

**Examples of individual food allergens provided are not all-inclusive, other foods may apply.*

Adjustment to meal preparation (i.e. food puree) and /or serving time(s):

Food Management Plan

What are the student's possible reactions/symptoms to the indicated allergen(s) or conditions?

_____

REQUIRED List all acceptable and safe food or beverage substitutes:

_____

_____

Comments: _____

_____

_____

Prescribing Physician/Medical Authority Name Printed **Date** **Prescribing Physician/Medical Authority Signature**

FOR FOOD SERVICE NOTES (Other information, please see back)

Date Received:	By: (*employee signature*)
Date Implemented:	By: (*employee signature*)
Other information:	