

**BEACH PARK COMMUNITY CONSOLIDATED  
SCHOOL DISTRICT #3**

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**Child Nutrition Programs  
PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION**

CHILD'S NAME	AGE	DATE
SCHOOL/FACILITY NAME	ADDRESS (Street, City, State, Zip Code)	

Parent/Guardian:

This school/facility participates in a federally-funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable food accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable food accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form. If you have any questions, please contact MONIKA JANKOVICS at (847) 599-5067.  
Telephone (Include Area Code) Name

**PHYSICIAN STATEMENT**

1. Does child have a disability according to 7 CFR Part 15d that requires food accommodation? (*Does he/she have a "physical or mental impairment which substantially limits one or more major life activities"?*)  
 No **If no, go to item 2 below.**  
 Yes **If yes, provide the following information and complete items 3, 4, and 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 medical problem which restricts the child's diet and complete items 3, 4, and 5 below.
  
3. List food/type of food to be omitted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.
  
4. List food/type of food to be substituted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.
  
5. \_\_\_\_\_  
Date Signature of Physician
  
6. \_\_\_\_\_  
Date Signature of Parent/Guardian

**FOR SCHOOL USE ONLY:**

Form received on \_\_\_\_\_.

Form incomplete. Parent contacted on \_\_\_\_\_.

Form complete. Accommodation will not be made.      Child does not have a disability      Request not reasonable

Form complete. Accommodations will begin on \_\_\_\_\_.

\_\_\_\_\_ \_\_\_\_\_  
Date Signature of Food Service Director/Contact