

GLENVIEW SCHOOL DISTRICT 34
FOOD & NUTRITION SERVICES DEPARTMENT
ANNUAL MODIFIED MEAL REQUEST FORM

Dear Parent/Guardian,

If your child plans to participate in the meal program and requires a meal accommodation, please complete information below and ask your child's doctor to complete the Physician section of the form and return. **A parent/guardian also needs to contact the food service department to discuss a meal plan for your child.**

Stacy Lenihan
Director of Food & Nutrition Services
slenihan@glenview34.org
Fax: 847-729-6251

Child's Name: _____ School: _____ Grade: _____
Parent/Guardian's Phone Number: _____ Email: _____

Parent/Guardian's Printed Name

Parent/Guardian's Signature

Date

Physician Statement

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

Preference OR Mental or physical impairment or disability. Please list the disability:

2. How does the disability restrict the child's diet? _____

3. List accommodations being requested, including foods to omit: _____

4. List acceptable safe food substitutes: _____

Printed Name of Physician

Signature of Physician

Date