acd Establishing Healthy Eating Habits To Last A Lifetime

Michigan Office
139 W. Lake Lansing Rd., Suite 120 • East Lansing, MI 48823
Telephone: (800) 234-3287 • FAX: (517) 332-5543

Illinois Office
4415 W. Harrison St., Suite 535 • Hillside, IL 60162
Telephone: (800) 284-5273 • FAX: (708) 236-0872

www.acdkids.org

CACFP REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant.

1. Center Name:	2. Center ACD Number:	3. Center Telephone:
4. Name of Child:		5. Child Age:
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:

8. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to instructions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. One of the following licensed medical professionals must sign this form: **licensed physician (MD or DO), physician's assistant (PA), or nurse practitioner (NP).**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP) or speech pathologist must sign this form.**

☐ Participant *does not have a disability*, but is requesting a special accommodation for a **fluid milk substitute** that meets the USDA nutrient standards for non-dairy beverages offered as milk substitutes. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, registered dietitian nutritionist, nurse practitioner, or parent/guardian may sign this form.**

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (please describe in detail to ensure proper implementation- use extra pages as needed)

12. Foods to be omitted and substitutions: (please list specific foods to be omitted and suggested substitutions; you may attach a sheet with additional information as needed.)

A. Food(s) To Be Omitted:	B. Suggested Substitution(s)

13. Indicate Texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

14. Adaptive Equipment:

15. Signature of Provider:	16. Printed Name:	17. Telephone:	18. Date:
19. Signature of Medical Authority:	20. Printed Name: (include credentials)	21. Telephone:	22. Date:

REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS INSTRUCTIONS

1. **School/Agency Name:** Print the name of the school or agency that is providing the form to the parent.
2. **Site Name:** Print the name of the site where meals will be served (e.g., XYZ school, XYZ child care center, XYZ family day care home, etc.).
3. **Site Telephone:** The telephone number of site where meal will be served. See #2.
4. **Name of Child:** Print the name of the child or adult participant to whom the information pertains.
5. **Participant Age:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent/Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Parent/Guardian Telephone:** Print the telephone number of parent or guardian.
8. **Check One:** Check a box ( ) to indicate whether participant has a disability, does not have a disability or does not have a disability but is requesting special accommodation for fluid milk substitution.
9. **Disability or medical condition requiring a special meal or accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).
10. **If participant has a disability, provide a brief description of participant's major life activity affected by the disability:** Describe how the physical or medical condition affects the participant. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **Diet prescription and/or accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **(A) Food(s) to be omitted:** List specific foods that must be omitted. For example,"exclude fluid cow's milk." **(B) Suggested substitution(s):** List specific foods to include in the diet. For example, "Nutritionally equivalent to non-dairy beverage."
13. **Indicate texture:** Check a box ( ) to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. Examples may include: sippy cup, large handled spoon, wheel-chair accessible furniture, etc.
15. **Signature of Provider:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation. SIGNATURE REQUIRED IF PARTICIPANT HAS A DISABILITY.
20. **Printed Name:** Print name of medical authority. Include credentials.
21. **Telephone:** Telephone number of medical authority.
22. **Date:** Date medical authority signed form.
