acd Establishing Healthy Eating Habits To Last A Lifetime

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CACFP REQUEST FOR SPECIAL MEALS and/or ACCOMMODATIONS

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

1. School/Sponsor Name:	2. Site Name:	3. Site Telephone:

4. Name of Participant/Student:	5. Participant Age:

6. Check One (Refer to instructions on reverse side of this form):

☐ **A.** Participant has a disability* or a medical condition which requires a special meal or accommodation. Program operators are required to make reasonable substitutions to meals for participants with a disability/medical condition that restricts their diet on a case-by-case basis when signed by a licensed medical professional. **A licensed physician (MD or DO), physician's assistant (PA),** or **nurse practitioner (NP) must sign this request.**

☐ **B.** Participant is requesting a special meal or accommodation due to religious, cultural or personal preference. **Any substitutions must fully meet the meal pattern.** Program operators are encouraged to make reasonable substitutions to meals on a case-by-case basis but are not required to do so.
A parent/guardian or adult participant may sign this request.

7. Disability Definition: The Americans with Disabilities Act (ADA) Amendment Act defines a person with a "disability" as any person who has a physical or mental impairment which substantially limits one or more "major life activities," has a record of such impairment, or is regarded as having such impairment **"Major life activities"** include, *but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.*
USDA Policy Memorandum on Modifications to Accommodate Disabilities in the CACFP and SFSP.

7. Foods to be omitted and substitutions (required): *Please list specific foods to be omitted and suggested substitutions. Attach a sheet with additional information as needed.*

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

8. Brief description of how exposure to this food affects participant:

9. Diet prescription and/or accommodation *(please describe in detail to ensure proper implementation-use extra pages as needed; see instructions on reverse side)* if applicable:

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

11. List Adaptive Equipment if required:

12. Signature of Parent/Guardian/Participant:	13. Printed Name:	14. Telephone:	15. Date:
16. Signature of Medical Professional:	**17. Printed Name: (include credentials)**	**18. Telephone:**	**19. Date:**

Revised: September 2019

REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS INSTRUCTIONS

1. **School/Sponsor Name:** Print the name of the school or Sponsor that is providing the form to the family.
2. **Site Name:** Print the name of the site where meals will be served (e.g., XYZ School, XYZ Child Care Center, etc.)
3. **Site Telephone:** The telephone number of site where meal will be served. See #2.
4. **Name of Participant/Student:** 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. **Check One:**
   A. Check box to indicate participant has a disability/medical condition which restricts their diet (example: Celiac disease, peanut or tree nut allergy, etc.) ***or***
   B. Participant is requesting a special dietary accommodation due to religious, cultural or personal preference (example: Vegan diet; Hindu; Jewish dietary pattern; Islamic dietary pattern, etc.).
7. **Food(s) to be omitted and suggested substitution(s) (Required):** List specific foods that must be omitted. For example: "exclude pork." Suggest foods to include in the diet. For example: "Substitute beef, poultry, eggs, beans/legumes."
8. **Brief description of how exposure to this food affects participant:** Describe how exposure to the allergen(s) and/or food(s) affects the participant. For example: "Exposure to peanuts causes a life-threatening reaction" or "pork is not allowed under Islamic dietary law".
9. **Diet prescription and/or accommodation:** Describe a specific diet or accommodation that has been prescribed by a licensed physician. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
10. **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."
11. **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.
12. **Signature of Parent/Guardian/Participant:** Signature of parent/guardian or adult participant requesting the accommodation.
13. **Printed Name:** Print name of parent/guardian or adult participant completing the form.
14. **Telephone:** Telephone number of parent/guardian or adult participant.
15. **Date:** Date parent/guardian or adult participant signs form.
16. **Signature of Medical Professional:** Signature of medical professional.
17. **Printed Name with Credentials:** Printed name of licensed medical professional, including professional credentials.
18. **Telephone:** Telephone number of licensed medical professional.
19. **Date:** Date medical professional signs form.

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