acd
Establishing
Healthy Eating Habits
To Last A Lifetime

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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. Provider Name/Site Name:	2. ACD Provider Number:	3. Provider Telephone:
4. Name of Participant:		5. Participant Date of Birth:
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:

8. Check One:

☐ Participant has a disability 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 other non-disability related 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. Granting the request of a non-dairy milk substitute is at the discretion of the facility. **A licensed physician, physician's assistant, registered dietitian nutritionist, nurse practitioner, or parent/guardian may sign this form.**

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

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

11. 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)

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

13. Adaptive Equipment (if necessary):

14. Signature of Parent/Guardian:	15. Printed Name:	16. Telephone:	17. Date:
18. Signature of Medical Authority:	19. Printed Name: (Include credentials)	20. Telephone:	21. Date:

Sponsor Use Only

_____ _____ ☐ Approved ☐ Denied

Supervisor Signature Date

Revised 1/2019

REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS INSTRUCTIONS

1. **Provider Name/Site Name:** Print the name of the Provider or child care facility supplying the form to the parent and site where meals will be served (e.g. XYZ child care center, XYZ family day care home)
2. **ACD Provider Number:** Print your six digit ACD Provider number or four digit center number
3. **Provider Telephone:** The telephone number of site where meal will be served. See #1.
4. **Name of Participant:** Print the name of the child participant to whom the information pertains.
5. **Participant Date of Birth:** Print the participant's 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 the parent/guardian.
8. **Check One:** Select the appropiate box to indicate whether participant has a disability, does not have a disability but is requesting a special meal or accomodation, or does not have a disability but is requesting special accommodation for a fluid milk substitution.
9. **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: "Consuming peanuts causes a life-threatening reaction."
10. **Diet prescription and/or accommodation:** Describe the specific diet or accommodation that has been prescribed by a medical authority 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."
11. **(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 non-dairy beverage."
12. **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."
13. **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.
14. **Signature of Parent/Guardian:** Signature of parent/guardian requesting the accommodation.
15. **Printed Name:** Print name of parent/guardian completing the form
16. **Telephone:** Telephone number of parent/guardian
17. **Date:** Date parent/guardian signs form.
18. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation. SIGNATURE REQUIRED IF PARTICIPANT HAS A DISABILITY.
19. **Printed Name:** Print name of medical authority. Include credentials.
20. **Telephone:** Telephone number of medical authority.
21. **Date:** Date medical authority signed form.

When form is complete mail, fax, or email to ACD office for documentation of records.

Disability Definition: The Americans with Disabilities Act Amendment Act defines a "disability," in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual. (For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008). More Information regarding the ADAAA, which expanded the definition of disability, see the Comparison of ADA and ADAAA sheet (http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf).

This project is funded at least in part by USDA funds through the Michigan Department of Education and/or the Illinois State Board of Education.

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Fluid Milk Substitute Request

Dear Parent/Guardian:

Congratulations! Your child care provider/facility participates in the Child and Adult Care Food Program (CACFP). Participating in CACFP means they care about good nutrition. They will introduce and serve a variety of nutritious foods for your child(ren) to eat and will serve foods appropriate to meet the nutritional requirements for his or her health and well-being. Depending upon the hours in care, your child care provider/facility may serve breakfast, morning snack, lunch, afternoon snack, supper, and/or evening snack.

Fluid milk is a required meal component for breakfast, lunch, and dinner. It is an optional component for snack. In the case of a participant who cannot consume fluid milk due to medical or other special dietary needs other than disability, non-dairy beverages may be served in substitution of fluid milk. CACFP requires the non-dairy substitute to be nutritionally equivalent to milk and meet the following nutritional standards.

Required Nutrients	Required Amounts Per Cup	% DV
Calcium	276 mg	28%
Protein	8 g	16%
Vitamin A	500 IU	10%
Vitamin D	100 IU	25%
Magnesium	24 mg	6%
Phosphorus	222 mg	22%
Potassium	349 mg	10%
Riboflavin	.44 mg	26%
Vitamin B-12	1.1 mcg	18%

If your child cannot consume fluid milk due to medical or other special dietary needs (other than a disability), please complete the following "Participant/ Parent/ Guardian Section" and return this completed form to your provider.

Parent/Guardian Section - Please Complete

(Participant's Name) **(Age)** **(Substitute Requested)**

Please describe the medical or other special dietary needs that restrict participant from consuming cow's milk:

Participant/Parent/Guardian Section - Continued

Please enter your requested product's nutritional requirements in the table below. It should be compared to the nutritional standards listed to show the nutritional equivalence is met or exceeded.

Required Nutrients	Required Amounts Per Cup	% DV	Per Cup or % DV in Substitute Product
Calcium	276 mg	28%	
Protein	8 g	16%	
Vitamin A	500 IU	10%	
Vitamin D	100 IU	25%	
Magnesium	24 mg	6%	
Phosphorus	222 mg	22%	
Potassium	349 mg	10%	
Riboflavin	.44 mg	26%	
Vitamin B-12	1.1 mcg	18%	

☐ I choose to provide the substitute product to my child's provider/child care facility. By providing a creditable milk substitute, I understand that the provider may receive meal reimbursement for the meal/snack served.

☐ I choose to not provide the substitute requested. I understand my provider/child care facility is not required, but has the discretion to, purchase and provide _____ as requested
(Name of Substitute)

Parent/Guardian Signature _____ **Date** _____

Provider Section- Please review the above nutrient analysis of the substitute requested by the parent/guardian and this section. Please keep this form on file.

I have determined the nutritional quality of the non-dairy milk substitute requested by comparing the requested substitute's nutritional values to the approved values. The substitution requested is:

☐ **CREDITABLE** ☐ **NOT CREDITABLE**

I understand that I have the discretion to purchase and provide a creditable substitute as requested, if the parent/guardian does not provide the non-diary milk substitute beverage. I understand I may only claim meal reimbursement for eligible meals.

Provider Signature _____ **Date** _____

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Sponsor Use Only

Supervisor Signature _____ Date _____

☐ Approved
☐ Denied