Medical Plan of Care for Child and Adult Care Food Program

(Children with Disabilities and Non-Disabling Special Dietary Needs)

The following child is a participant in the United States Department of Agriculture (USDA) Child and Adult Care Food Program.

- USDA regulations 7CFR Part 15B require substitutions or modifications in program meals for children whose **disability** restricts their diet and is supported by a statement signed by a **licensed physician**. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."
- The child care facility may choose to accommodate a child with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).

Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)

Child's Name		Date of Birth	M ☐ F ☐
Name of School/Center/Program		Grade Level/Classroom	
Parent's/Guardian's Name		Address, City, State, Zip Code	
( )	( )		
Home Phone	Work Phone		

Part 2: To be completed by Physician/Medical Authority

Disability/Special Dietary Needs

Does the child have a **disability**? Yes ☐ No ☐

If Yes,
Please describe the major life activities affected by the disability.

Does the child's disability affect their nutritional or feeding needs? Yes ☐ No ☐

If the child **does not have a disability***, does the child have special nutritional or feeding needs? Yes ☐ No ☐
(*These accommodations are optional for child care facility to make)

If the child has a disability or special dietary/feeding need, please complete Part 3 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority.

Part 3: To be completed by Physician/Medical Authority

Diet Order

List any dietary restrictions, such as food allergies, intolerances or restrictions:

List specific foods to be substituted (Substitution cannot be made unless section is completed):

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All."

Cut up/chopped into bite sized pieces:

Finely Ground:

Pureed:

List any special equipment or utensils needed:		
Indicate any other comments about the child's eating or feeding patterns:		
Physician's Name and Office Phone Number		Office Stamp
Physician/Medical Authority's Signature		Date
Part 4: Parent Signature		Date
Part 5: Child Care Facility Signature		Date

Signing this section is <u>optional</u>, but may prevent delays by allowing us to speak with the physician.

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ (center/facility) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature:_____ Date:_____

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

Parent confirmed no change in diet order. ____ Date _____ ____ Date _____ ____ Date_____

____ Date_____ ____ Date _____ ____ Date _____ ____ Date _____ ____ Date_____

Reset Form