

## 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
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Physician/Medical Authority's Signature	Date
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<b>Part 4: Parent Signature</b>	Date
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<b>Part 5: Child Care Facility Signature</b>	Date
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**Signing this section is optional, 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 \_\_\_\_\_