MICHIGAN Department of Education

Michigan Department of Education
Office of School Support Services

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. School/Agency Name:	2. Site Name:	3. Site Telephone:

4. Name of Participant/Student:	5. Participant 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. 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. 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 Preparer:	16. Printed Name:	17. Telephone:	18. Date:
19. Signature of Medical Authority:	**20. Printed Name: (include credentials)**	**21. Telephone:**	**22. Date:**

Michigan Department of Education
Office of School Support Services

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, 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. **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:** 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. **Food(s) to be omitted and suggested substitution(s):** List specific foods that must be omitted. For example: "exclude fluid milk." List specific foods to include in the diet. For example: "Nutritionally equivalent 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 Parent/Guardian:** Signature of parent/guardian requesting the accommodation.
16. **Printed Name:** Print name of parent/guardian completing the form.
17. **Telephone:** Telephone number of parent/guardian.
18. **Date:** Date parent/guardian signs form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name with Credentials:** Print name of medical authority, including credentials.
21. **Telephone:** Telephone number of medical authority.
22. **Date:** Date medical authority signs form.

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).

Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

Michigan Department of Education
Child and Adult Care Food Program

Fluid Milk Substitute Request

Dear Parent/Guardian/Participant:

Congratulations! Your provider participates in the Child and Adult Care Food Program (CACFP). Participating in CACFP means the provider cares about good nutrition. The provider will introduce and serve a variety of nutritious foods for participants to eat and will serve foods appropriate to meet nutritional requirements for participants' health and well-being. Depending upon the hours in care, your provider will be serving breakfast, morning snack, lunch, afternoon snack, supper and/or a late snack.

Fluid milk is a required meal component for breakfast and lunch. (For CACFP participants, fluid milk is also required to be served during supper for children.) It is an optional component for a 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 milk 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	0.44 mg	26%
Vitamin B-12	1.1 mcg	18%

If you (participant) or your family member (parent/guardian) 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.

Participant/Parent/Guardian Section - Please Complete

Participant's Name:	Age:	Substitute Requested:

Please describe the medical or other special dietary need that restricts 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	0.44 mg	26%	
Vitamin B-12	1.1 mcg	18%	

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

_____ _____
Parent/Guardian Signature Date

Provider Section – Please complete 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 substitute requested is:

☐ **CREDITABLE** ☐ **NOT CREDITABLE**

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

_____ _____
Provider's Signature Date

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.