Dietary Restrictions & Substitutions Statement

The following statement is for United Stated Department of Agriculture (USDA) programs, including the **Child and Adult Care Food Program**.

USDA regulations 7CFR Part 15B requires substitution or modifications in school/program meals for children whose disabilities (defined below) restrict their diets. A child with a disability must be supplied substitutions in foods when that need is supported by a statement signed by a licensed physician. Food allergies which may result in severe, life-threatening (anaphylactic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physician/medical authority would be made.

- **"Disability"**: A physical or mental impairment which substantially limits one or more of an individual's major life activities.
- **"Major Life Activity"**, as defined by ADAAA: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and major bodily functions.
- **"Major Bodily Functions"** has been defined as: functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions.

The statement must include the following:

To be completed by Parent/Guardian

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

City _____ State _____ Zip Code _____

Phone Number: (Home) _____ (Work) _____

Parent/Guardian Signature: _____ Date: _____

To be completed by child's Physician or Medical Authority:

State the "disability" and major life activities affected: _____

_____

List the food allergies or food intolerances: _____

_____ _____

List any additional dietary restrictions or special diet: List the food or beverages to be substituted:

_____

_____

Physician's Name: _____ Office Number: _____

Physician/Medical Authority 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 child's physician or medical authority.