

# Dietary Restrictions & Substitutions Statement



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

USDA regulations 7CFR Part 15B require 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) reactions, 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 that 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.