C.B.S.

State Sponsored School and Summer Kosher Food Program

85 Suite F Tomlinson Road Huntingdon Valley, PA 19006

Phone: 215-938-0201/ FAX: 215-938-0205

Medical Plan of Care for Child and Adult Care Food Program

(Children with Disabilities and Non-Disabling Special Dietary Needs) **PAGE 1 of 2**

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)

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

*Child Name		*Date of Birth	F M
*Name of School/Center/Program **LITTLE SCHOLARS ACADEMY 5000005539** **(215) 342-9500**		*Grade Level/Classroom	
*Parents/Guardians Name(s)		*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 notes 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?.[1]

***Cut up/chopped into bite sized pieces:**

***Finely Ground:**

***Pureed:**