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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)**

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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's Name		*Date of Birth		M	F
*Name of School/Center/Program LITTLE SCHOLARS ACADEMY 5000005539 (215) 342-9500		*Grade Level/Classroom			
*Parent's/Guardian's Name		*Address, City, State, Zip Code			
* Home Phone	* Work Phone				
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***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".¹

*Cut up/chopped into bite sized pieces:

*Finely Ground:

*Pureed: