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: ______________________________________________________

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 the food or beverages to be substituted:

____________________________________________________

____________________________________________________

List any additional dietary restrictions or special diet:

________________________________________________________________________________________

________________________________________________________________________________________

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.