VIRGINIA CACFP
Child and Adult Care Food Program

SPECIAL DIETARY PRESCRIPTION FORM

1. School/Agency Name	2. Site Name	3. Site Telephone Number
4. Name of Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Telephone Number

8. Check One:

_____ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to instructions on the following page.) Schools and agencies participating in Federal Child Nutrition (CN) Programs must comply with requests for special meals and any equipment. **A LICENSED PHYSICIAN MUST SIGN THIS FORM.**

_____ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in Federal Child Nutrition (CN) Programs are encouraged to accommodate reasonable requests. **A LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER MUST SIGN THIS FORM.**

_____ Participant does not have a disability, but is requesting a special accommodation for a **fluid milk substitute** that meets the nutrition standards for non-dairy beverages offered as milk substitutes. Food preferences are NOT an appropriate use of this form. Schools and agencies participating in Federal Child Nutrition (CN) Programs are encouraged to accommodate reasonable requests. **A LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT, NURSE PRACTITIONER OR PARENT/GUARDIAN MUST SIGN THIS FORM.**

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (please *describe in detail* to *ensure proper implementation-use extra pages as needed)*

12. Foods to be omitted and substitutions: ***(Please list specific foods to be omitted and suggested substitutions. Attach additional information sheets as needed.)***

FOODS TO BE OMITTED	SUGGESTED SUBSTITUTIONS

13. Indicate texture ***(Please circle one)*****:**

REGULAR CHOPPED MECHANICAL SOFT PUREED

14. Adaptive Equipment:

15. Signature of Preparer*	16. Printed Name	17. Telephone Number	18. Date
19. Signature of Medical Authority*	20. Printed Name	21. Telephone Number	22. Date

*Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form. Parent/legal guardian signature is acceptable for fluid milk substitution for a child with special medical or dietary needs other than a disability.

The information on this form must be updated whenever necessary to reflect the current medical and/or nutritional needs of the participant.

This institution is an equal opportunity provider.