

 Policy #: N-4	Effective Date:	Page #: 1 of 3
Ref #: 1304.23 (c)(6)	Policy Council Approval Date: 8/28/07, 3/25/08	Revision Date: 4/12/07, 3/4/08

COMPONENT: NUTRITION

SUBJECT: MEDICALLY-BASED DIETS FOR CHILDREN WITH SPECIAL NEEDS

PERFORMANCE OBJECTIVE: Accommodating special diets or dietary requirements ensures a child’s health will not be jeopardized and that individual needs are met.

PROCEDURE: CACFP Policies and Procedures state: Allowable Food Substitutions
“Substitutions are allowed in writing by a recognized medical authority. Copies of the orders should be on file at the sponsoring organization office and at the home meal service site. The order should specify the food or foods the participant is not to eat and the food or foods that may be substituted. Recognized medical authorities include, but are not limited to, physicians and registered nurses.”

When changes have to be made due to medical or religious reasons those changes along with substitutions will be noted on the classroom’s menu, and returned to the Lead Cook. Information regarding food allergies and restrictions will be maintained in each kitchen or classroom in a manner that maintains the confidentiality of the child. **A brightly colored sheet of paper will be posted in the kitchen area stating food allergies and/or special diets. Full time staff will ensure substitutes and volunteers are made aware of the allergies within the classrooms and the confidentiality of these students.**

Special eating utensils will be provided for children with disabilities when required for better manipulation.

**Medical Statement for Child with Disability
Requiring Special Diet**

Part I (to be filled out by facility)

Date _____

Name of Child _____

Name of Facility _____

Facility Attended by Child _____

Part II (to be filled out by physician)

Patient's Name _____ Age _____

Diagnosis _____

Describe the patient's disability and the major life activity affected by the disability:

Does the disability restrict the individual's diet? Yes ____ No ____

If yes, list food(s) to be omitted from the diet and food(s) that may be substituted:

(DIET ORDER)

Special Equipment: _____

Physician Signature

Date

**Medical Statement for Child without Disability
Requiring Special Diet**

Part I (to be filled out by facility)

Date _____

Name of Child _____

Name of Facility _____

Facility Attended by Child _____

Part II (to be filled out by physician)

Patient's Name _____ Age _____

Diagnosis _____

Describe the medical or other special dietary needs that restrict the child's diet:

List food(s) to be omitted from the diet and food(s) that may be substituted:

(DIET ORDER)

Special Equipment: _____

Physician Signature

Date