## **CACFP Meal Modification Form**

**Important!** Select the applicable meal modification category from the three listed below. Then carefully read and follow the procedures for that category. The center/home will return an incomplete Meal Modification Form to the parent/guardian. If you have questions about this form, the center/home will assist you.

## 1. Modification due to a disability:

- A center/home is <u>required</u> to make meal modifications prescribed by a medical authority to accommodate a
  participant's disability. See the definition of disability on the back of this form.
- Part B of this form must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced registered nurse practitioner (ARNP) authorized by their responsible licensed physician.
- Parts A and C of this form must also be completed before the center/home can make meal modifications.
- The meal modifications will continue until the medical authority requests that the modifications be changed or stopped by completing Form 4-G with the change. The form is available from the center/home.
- It is strongly recommended that the medical authority annually update the prescribed diet order.

## Modification due to a food allergy/intolerance, or other medical condition that does not rise to the level of a disability:

- A center/home has the <u>option</u> to make meal modifications prescribed by a medical authority due to a food allergy/intolerance or other medical condition that does not rise to the level of a disability.
- Part B of this form must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced registered nurse practitioner (ARNP) authorized by their responsible licensed physician.
- Parts A and C of this form must also be completed before the center/home can make meal modifications.
- If a center/home chooses to make the meal modifications, they will continue until a medical authority requests that the modifications be changed or stopped by completing Form 4-G. The form is available from the center/home.
- It is strongly recommended that a medical authority annually update the prescribed diet order.

## 3. Substitution for fluid cow's milk due to lactose intolerance, allergy, religious, ethical or cultural reasons:

- A center/home has the <u>option</u> to make a substitution for fluid cow's milk that is requested by a parent/guardian, but that is not prescribed by a medical authority.
- Parts A and D of this form must be completed before the center/home can make a substitution for fluid cow's milk.
- If a center/home chooses to provide such a substitution, they will continue until a parent/guardian requests that the substitution be changed or stopped by completing Form 4-G. The form is available from the center/home.

Part A. Participant, Parent/Guardian & Center/Home Information – To be completed by a parent/guardian or center/home contact person					
Participant's Name:	Date of Birth:				
Parent/Guardian's Name:	Parent/Guardian's Phone:				
Center/Home Name:	Center/Home's Phone:				
Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.					
Check ONE:					
☐ Disability OR					
☐ Food allergy/intolerance or other medical condition that does not rise to the level of a disability					
2. Specify the disability, food allergy/intolerance, or medical condition related to the prescribed diet order.					
3. If the participant has a disability, what major life activity is affected? Example: Allergy to peanuts affects ability to breathe.					
4. Type of Special Diet:					
☐ Check if not applicable OR specify the type of special diet	(e.g. gluten-free, diabetic, etc.).				

5.	Modified Texture:	☐ Not Applicable	☐ Chopped	Ground	☐ Pureed			
6.	Modified Thickness of Liquids:	☐ Not Applicable	☐ Nectar	☐ Honey	Spoon or Pudding Thick			
7.	7. Special Feeding Equipment:  Check if not applicable OR list special feeding equipment (e.g. large handled spoon, sippy cup, etc.).							
8.	8. Foods to be Omitted and Substituted:							
	☐ Check if not applicable OR list special foods to be omitted and substituted. If more space is needed, sign and attach additional sheet of paper.							
	IMPORTANT: For a participant who does <u>not</u> have a recognized disability, the only fluid cow's milk substitutions allowed by USDA are: (1) lactose-free fluid cow's milk or a (2) non-dairy beverage with a nutrient profile equivalent to fluid cow's milk as specified in federal regulations. Currently the only beverages meeting these specifications are certain brands of soymilk.							
Omit Foods Listed Below:			S	ubstitute Foods Listed Be	elow:			
9. Medical Authority's Information								
Signature: Title:								
Pr	rinted Name:		Phone:		Date:			
Pa	art C. Parent/Guardian Permission -	- To be completed by a p	parent/guardian					
I give permission for the center/home responsible for implementing my participant's prescribed diet order to discuss my participant's special dietary accommodations with any appropriate center/home staff and to follow the prescribed diet order for my participant's CACFP meals. I also give permission for my participant's medical authority to further clarify the prescribed diet order on this form if requested to do so by center/home.								
	equested to do so by center/home.							
	equested to do so by center/home. arent/Guardian's Signature:		Date:					
Pa Pa				rgy, Vegan Diet, Religio	ous, Cultural or			
Pa Pa Et	arent/Guardian's Signature: art D. Request Substitution for Fluid	a parent/guardian	ctose Intolerance, Alle					
Pa Pa Et	arent/Guardian's Signature:  art D. Request Substitution for Fluid thical Reasons – To be completed by stead of fluid cow's milk, please provid	a parent/guardian e the participant named	ctose Intolerance, Alle		e (Check ONE):			
Pa Pa Et	arent/Guardian's Signature:  art D. Request Substitution for Fluid thical Reasons – To be completed by stead of fluid cow's milk, please provid	a parent/guardian e the participant named	ctose Intolerance, Alle	ith the following substitut	e (Check ONE):			
Pa P	arent/Guardian's Signature:  art D. Request Substitution for Fluid thical Reasons – To be completed by stead of fluid cow's milk, please provid  Lactose-free cow's milk	a parent/guardian e the participant named airy beverage with a nutr  Act of 1973 and the Ame al impairment which sub-	in Part A. of this form with the profile equivalent to Date:	ith the following substitut o fluid cow's milk per fede Act (ADA), a "person with	e (Check ONE): eral regulations a disability" means			

Individuals who take mitigating measures to improve or control any of the conditions recognized as a disability are still considered to have a disability and require an accommodation.

Cancer

• Drug addiction and alcoholism