BOYS & GIRLS CLUBS OF WEST CENTRAL MISSOURI

(FOOD SUBSTITUTION DUE TO ALLERGIES OR INTOLERANCE)

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. SPONSOR Name	2. Site Name, if different from #1.	3. Site Telephone Number
Boys & Girls Clubs of West Central Missouri		660-826-8331
4. Name of Participant		**5. 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.) CACFP, schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive 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. CACFP, schools and agencies participating in federal nutrition 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 nutrient standards for non-dairy beverages offered as milk substitutes. Food preferences are not an appropriate use of this form. CACFP, schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, nurse practitioner or parent or guardian may 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 required substitution; attach a sheet with additional information as needed*)

A. Foods To Be Omitted	B. Foods to be Substituted

13. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ 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 should be updated to reflect the current medical and/or nutritional needs of the participant.