Child and Adult Care Food Program (CACFP)
Fluid Milk Substitution Request Form

MICHIGAN Department of Education

Participant does not have a disability/medical condition but is requesting a fluid milk substitution that meets USDA nutrient standards for non-dairy beverages.

Non-Creditable Non-Dairy Beverages include: Almond, cashew, coconut, hemp, oat, pea, and rice milks do not contain enough protein to be a creditable non-dairy beverage. Water and juice are also not creditable non-dairy beverages. Non-creditable non-dairy beverages cannot be served as a milk substitution. **These beverages require a completed CACFP Request for Special Meals and/or Accommodations form.**

Enter the name of the requested product and the product's nutritional requirements in the table below. It must be compared to the nutritional standards listed to show the nutritional equivalence is met or exceeded.

Requested Product Name: _____

Required Nutrients	Required Amounts Per Cup	%DV	Per Cup or %DV in Substitute product
Calcium	276 mg	28%	
Protein	8 g	16%	
Vitamin A	500 IU	10%	
Vitamin D	100 IU	25%	
Magnesium	24 mg	6%	
Phosphorus	222 mg	22%	
Potassium	349 mg	10%	
Riboflavin	0.44 mg	26%	
Vitamin B-12	1.1 mcg	18%	

☐ Creditable ☐ Not Creditable Date verified: _____

☐ I choose to provide the substitute product to my provider. By providing a creditable milk substitute, I understand that the provider may receive meal reimbursement for the meal/snack served.

☐ I choose to not provide the substitute requested. I understand the provider is not required, but has the discretion to, purchase and provide fluid milk substitutions as requested.

Participant Name: _____ Age:_____

Parent/Guardian Signature: _____ Date:_____

Provider's Signature: _____ Date :_____

Non-Discrimination Statement

In accordance with Federal law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, and reprisal or retaliation for prior civil rights activity. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible State or local Agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information is available in languages other than English.

To file a complaint alleging discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

Michigan Department of Education
Office of Health and Nutrition Services

CACFP REQUEST FOR SPECIAL MEALS and/or ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant.

1. School/Sponsor Name:	2. Site Name:	3. Site Telephone:

4. Name of Participant/Student:	5. Participant Age:

6. Check One (Refer to instructions on reverse side of this form):

☐ **A.** Participant has a disability* or a medical condition which requires a special meal or accommodation. Program operators are required to make reasonable substitutions to meals for participants with a disability/medical condition that restricts their diet on a case-by-case basis when signed by a licensed medical professional. **A licensed physician (MD or DO), physician's assistant (PA),** or **nurse practitioner (NP) must sign this request.**

☐ **B.** Participant is requesting a special meal or accommodation due to religious, cultural or personal preference. **Any substitutions must fully meet the meal pattern.** Program operators are encouraged to make reasonable substitutions to meals on a case-by-case basis but are not required to do so. **A parent/guardian or adult participant may sign this request.**

***Disability Definition:** The Americans with Disabilities Act (ADA) Amendment Act defines a person with a "disability" as any person who has a physical or mental impairment which substantially limits one or more "major life activities," has a record of such impairment, or is regarded as having such impairment **"Major life activities"** include, *but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions*. USDA Policy Memorandum on Modifications to Accommodate Disabilities in the CACFP and SFSP.

7. Foods to be omitted and substitutions (required): *Please list specific foods to be omitted and suggested substitutions. Attach a sheet with additional information as needed.*

A. Food(s) To Be Omitted:	B. Suggested Substitution(s)
_____	_____
_____	_____
_____	_____

8. Brief description of how exposure to this food affects participant:

9. Diet prescription and/or accommodation *(please describe in detail to ensure proper implementation- use extra pages as needed; see instructions on reverse side)* if applicable:

10. Indicate Texture:
☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

11. List Adaptive Equipment if required:

12. Signature of Parent/Guardian/Participant:	13. Printed Name:	14. Telephone:	15. Date:
16. Signature of Medical Professional:	**17. Printed Name: (include credentials)**	**18. Telephone:**	**19. Date:**

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MICHIGAN Department of Education

REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS INSTRUCTIONS

1. **School/Sponsor Name:** Print the name of the school or Sponsor that is providing the form to the family.
2. **Site Name:** Print the name of the site where meals will be served (e.g., XYZ School, XYZ Child Care Center, etc.)
3. **Site Telephone:** The telephone number of site where meal will be served. See #2.
4. **Name of Participant/Student:** Print the name of the child or adult participant to whom the information pertains.
5. **Participant Age:** Print the age of the participant. For infants, please use date of birth.
6. **Check One:**
   A. Check box to indicate participant has a disability/medical condition which restricts their diet (example: Celiac disease, peanut or tree nut allergy, etc.) ***or***
   B. Participant is requesting a special dietary accommodation due to religious, cultural or personal preference (example: Vegan diet; Hindu; Jewish dietary pattern; Islamic dietary pattern, etc.).
7. **Food(s) to be omitted and suggested substitution(s) (Required):** List specific foods that must be omitted. For example: "exclude pork." Suggest foods to include in the diet. For example: "Substitute beef, poultry, eggs, beans/legumes."
8. **Brief description of how exposure to this food affects participant:** Describe how exposure to the allergen(s) and/or food(s) affects the participant. For example: "Exposure to peanuts causes a life-threatening reaction" or "pork is not allowed under Islamic dietary law".
9. **Diet prescription and/or accommodation:** Describe a specific diet or accommodation that has been prescribed by a licensed physician. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
10. **Indicate Texture:** Check a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular."
11. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. Examples may include sippy cup, large handled spoon, wheel-chair accessible furniture, etc.
12. **Signature of Parent/Guardian/Participant:** Signature of parent/guardian or adult participant requesting the accommodation.
13. **Printed Name:** Print name of parent/guardian or adult participant completing the form.
14. **Telephone:** Telephone number of parent/guardian or adult participant.
15. **Date:** Date parent/guardian or adult participant signs form.
16. **Signature of Medical Professional:** Signature of medical professional.
17. **Printed Name with Credentials:** Printed name of licensed medical professional, including professional credentials.
18. **Telephone:** Telephone number of licensed medical professional.
19. **Date:** Date medical professional signs form.

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