The Child and Adult Care Food Program (CACFP) addresses the nutritional needs of young children in family child care. Child Care Providers are required to serve meals and snacks (including milk) that meet USDA meal pattern requirements, including meals and snacks served to participants with disabilities.

**What is a disability?** Physical or mental impairment that substantially limits one or more major life activities (includes eating, breathing, digestive and respiratory functions, etc.). Most physical and mental impairments will constitute a disability, it does not need to be life threatening. Ex. Digestion is impaired by lactose intolerance, whether or not consuming milk causes severe distress.

**THIS CHILD IS ONE YEAR OR OLDER** and requires a dietary change that does not meet the USDA meal pattern requirements due to a disability (see above definition).

Specify change needed and/or food(s) to omit as well as reason:

______________________________________________________________________________________________________________________________________________________

Specify allowable substitution(s):

______________________________________________________________________________________________________________________________________________________

**THIS CHILD IS AN INFANT (LESS THAN ONE YEAR)** and requires a dietary change that does not meet the USDA meal pattern requirements due to a disability (see above definition).

☐ Infant may have iron-fortified infant formula omitted.

Reason for omission: ____________________________________________________________________________________________________________________________________________________________________________________________

Substitute(s) ______________________________________________________________________________________________________________________________________________________________________________________

☐ Infant: Other change

Reason for omission: ____________________________________________________________________________________________________________________________________________________________________________________________

Substitute(s) ______________________________________________________________________________________________________________________________________________________________________________________

Print physician, physician assistant, or nurse practitioner (DPNP) Name

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<th>Signature and Date</th>
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<td>Clinic Name and phone #</td>
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