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Division of Public Health

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CACFP 13-6
SFSP 13-11

Memorandum

To: Institutions Participating in the Child and Adult Care Food Program
Sponsors of the Summer Food Service Program

From: Arnette Cowan, Head
Special Nutrition Programs

Subject: Guidance Related to the ADA Amendments Act

The purpose of this memorandum is to provide schools, institutions, facilities, sites, and sponsors participating in the Child Nutrition Programs (CNP) with additional clarifications on making dietary accommodations for children with disabilities as required under Section 9(a) of the Richard B. Russell National School Lunch Act, 42 USC 1758(a), CNP regulations and in accordance with the Americans with Disabilities Act Amendments Act of 2008 (ADAAA), P.L. 110-325. The ADAAA, as explained in further detail in the next paragraph below, amended the Federal definition of disability, broadening it to cover additional individuals. Because of this broader definition, it is reasonable that CNP operators may see more children identified by their licensed physician as having a food-related disability than were identified previously. Program operators should note, however, that the process for identifying children with disabilities requiring an accommodation has not changed. The CNPs continue to require that participants seeking an accommodation for a disability that is food-related must provide a statement from a licensed physician (as defined by the State) identifying the food-related disability and indicating the required meal accommodation.

The ADAAA broadened the list of "Major Life Activities" for purposes of identifying individuals with disabilities and added a new category called "Major Bodily Functions", 42 USC 12102(2)(B). This law continues to include as "Major Life Activities": "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working." As amended by the ADAAA, Major Life Activities now also includes

"Major Bodily Functions" such as: "functions of the immune system**,** normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions." It is important to point out that 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.

The Food and Nutrition Service is working to update the guidance, *Accommodating Children with Special Dietary Needs in the School Nutrition Programs, Guidance for School Food Service Staff* (http://www.fns.usda.gov/cnd/guidance/special_dietary_needs.pdf), to reflect the broadened definition of disabilities. Institutions participating in the CACFP and sponsors participating in the SFSP should also refer to this resource until more specific guidance is made available.

Attached to this memo is a revised form "Medical Statement for CACFP and SFSP Participants Requiring Meal Modifications". Please use this form when documenting if a participant in your Institution or facility has a medical condition or disability as defined above.

If you have questions, please contact your regional consultant.

c: SNP Staff

Child and Adult Care Food Program (CACFP)
Summer Food Service Program (SFSP)
Medical Statement for CACFP and SFSP Participants
Requiring Meal Modifications

Dear Parent/Guardian:
This institution/sponsor participates in the Child and Adult Care Food Program (CACFP) and/or the Summer Food Service Program (SFSP) and must serve meals and snacks meeting the CACFP and/or SFSP requirements. If a participant has a documented disability that restricts his/her diet, the institution/sponsor is required to provide substitutions as identified by a Licensed Physician. If a participant has a documented medical condition that restricts his/her diet, institution/sponsor must have a medical statement from a Licensed Physician or Recognized Medical Authority (Physician's Assistant or Nurse Practitioner), the institution/sponsor at their discretion may provide the substitution. Please have your Physician or Recognized Medical Authority complete and sign this form. Return the completed form to this institution/sponsor.

Participant Information		
1. Name:	2. DOB:	
Disability or Medical Condition		
3. The participant has a disability which restricts his/her diet: **If yes is checked, complete numbers 5 – 9 and sign on line 13**	☐ Yes	☐ No
4. The participant has a medical condition that restricts his/her diet: **If yes is checked, complete numbers 5, 8-9 and sign on line 14**	☐ Yes	☐ No
5. What is the disability/medical condition requiring modification of meals?		
6. Explain why disability restricts participant's diet:		
7. **Major life activity affected by disability: (Check all that apply)** ☐ caring for one's self ☐ performing manual tasks ☐ seeing ☐ hearing ☐ eating ☐ sleeping ☐ walking ☐ standing ☐ lifting ☐ bending ☐ speaking ☐ breathing ☐ learning ☐ reading ☐ concentrating ☐ thinking ☐ communicating ☐ working **Major bodily functions affected by disability: (Check all that apply)** ☐ functions of the immune system ☐ normal cell growth ☐ digestive ☐ bowel ☐ bladder ☐ neurological ☐ brain ☐ respiratory ☐ circulatory ☐ endocrine ☐ reproductive functions		

Substitutions	
8. Identify Foods to Omit from Diet:	**9. Identify Foods that may be Substituted in Diet:**

Other Special Dietary Needs		
10. The participant requires caloric modifications:	☐ Yes	☐ No
11. If yes, provide the caloric modification: _____ calories per day		
12. Other therapeutic diets (please explain):		
For a participant with a disability **(If number 3 is checked yes, this form must be signed by a physician)**		
13.Signature of Physician:	**Date:**	
For a participant with a medical condition		
14. Signature of Recognized Medical Authority:	**Date:**	

Instructions for Completing the
Medical Statement for CACFP and SFSP Participants
Requiring Meal Modifications

Participant Information:

1. Provide the name of the participant who needs the modified meal.
2. Provide the date of birth of the participant .

Disability (formerly known as Handicapped Participant) or Medical Condition
7 CFR Subtitle A, Section 15b.3(i) Definitions:

3. The participant has a disability which restricts his/her diet: Check one. If yes is checked, complete numbers 5 through 9.

(i) *A person with a "disability"* means any person who has a "physical or mental impairment which substantially limits one or more major life activities of such individual; has a record of such impairment, or is regarded as having such an impairment."

(ii) The Americans with Disabilities Act Amendments Act (ADAAA) broadened the list of "Major Life Activities" for purposes of identifying individuals with disabilities and added a new category called "Major Bodily Functions." As amended by the ADAAA, Major Life Activities now also include Major Bodily Functions.

4. The participant has a medical condition that restricts the participant's diet: Check one. If yes is checked, complete numbers 5, 8 through 9.
5. Briefly describe the disability or medical condition that necessitates the meal modification.
6. If the condition is a disability, explain why disability restricts participant's diet.
7. If the condition is a disability, indicate which major life activity is affected by disability. 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. Check all major life activities that are affected by the disability. If the medical condition is not a disability leave this section blank.

Substitutions:

8. List the foods that must not be served to this participant.
9. For each food that must be omitted from the participant's diet list an alternate substitute that the participant is able to consume.

Other Special Dietary Needs:

10. Indicate whether the meal modification requires a caloric adjustment.
11. Indicate the type of caloric modification needed for the participant.
12. If the meal modification relates to a therapeutic diet or texture modification, please explain.

Health Care Provider Information:

13. If the meal modification is for a person with a disability, the institution/sponsor is required to make the modification and the form must be signed and dated by a physician.
14. If this meal modification is due to a medical condition not constituting a disability, the institution/sponsor is encouraged to make the substitution and the form must be signed and dated by a Recognized Medical Authority. (Physician, Physician Assistant, Nurse Practitioner)