Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Child Nutrition Programs
(503) 947-5894

Nutrition First CACFP

Meal Preference Request Form

Child Care Provider Name:	**Submit this form to:** Nutrition First CACFP P.O. Box 2316 Salem, OR 97308

Part I To be completed by Parent/Guardian, Adult Participant, or Nutrition First CACFP

Name of Participant: _____

Parent/Guardian Name: _____ Phone #: _____

Part II To be completed by Parent/Guardian or Adult Participant
Note: This form is for non-medical meal preference requests. If a medical meal accommodation is required, a Medical Statement must be completed instead.

1. Check one or more boxes: Additional instructions are available on the back of this form

☐ A. The participant requests a Nutritionally Equivalent Milk Substitute[5]

Nutritionally Equivalent Milk Substitute Available: **Please indicate choice by marking box below:**

☐ **8th Continent Soy Milk (Plain)**
☐ **Pacific Soy Ultra (Plain)**
☐ **Sunrich Natural Organic Soy Milk (Plain)**
☐ **Kirkland Organic Soy Milk (Plain)**
☐ **Walmart Great Value Soy Milk (original)**
☐ **Silk Original Soy Milk (original)**

☐ B. The participant requests other non-medical[5] food accommodations, fill out section below

Food(s) to be Omitted:	Suggested Substitution(s):
_____	_____
_____	_____

2. Signature and Date of Parent/Guardian or Adult Participant:

_____ _____ _____
Printed Name Signature Date

Part III Nutrition First CACFP Use Only

Accommodation(s) Made: _____

_____

Sponsor Signature: _____ Date: _____

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Instructions for completing the Meal Preference Request Form:

1. **Organization Name:** Include the name of the Sponsoring Organization that is providing the form
2. **Site/Provider Name:** Print the name of the site where meals will be served (e.g., ABC School, XYZ Child Care Center)
3. **Submit this form to:** Include the name and contact information for the organization staff who will be collecting the completed form
4. **Part I:** This section can be completed by the **Parent/Guardian, Adult Participant, or Organization**
    a. **Name of Participant:** Print the first and last name of the child or adult participant
    b. **Parent/Guardian Name:** Print the first and last name(s) of the parent or guardian. This is not required for adult participants.
    c. **Phone #:** Include a number for the parent/guardian in case of questions
5. **Part II:** This section must be completed by the **Parent/Guardian or Adult Participant** except for the Nutritionally Equivalent Milk Substitute Available section.
    a. In section 1 – **check one or more boxes**: Check all boxes that apply.
        i. A **Nutritionally Equivalent Milk Substitute** is defined as a non-dairy substitute that is nutritionally equivalent to cow's milk, as outlined in the National School Lunch Program (NSLP) regulations at 7 CFR 210.10(d)(3). Not all non-dairy substitutes will meet this requirement. For more information and a list of acceptable substitutes, refer to the ODE CNP Meal Accommodations and Modifications page.
        ii. **Nutritionally Equivalent Milk Substitute Available:** The Sponsoring Organization will include the full name and flavor of the Nutritionally Equivalent Milk Substitute that is available per the Organization's policy. If available, it must be provided at no extra charge for participants.
        iii. **A non-medical food accommodation** may include any meal accommodations due to religious, cultural, or personal preference (e.g., vegetarian, Kosher, etc.)
        iv. If the non-medical food accommodation is checked, include both the **food(s) to be omitted and the suggested substitution(s)**. Sponsoring Organizations may omit all food(s) as requested and may also accommodate suggested substitutions according to their organization's policies.
    b. In section 2 – **Signature and Date of Parent/Guardian or Adult Participant:** Print the full name of the parent/guardian or adult participant who is requesting the accommodation, sign, and date. This form will be considered incomplete if this section is not filled in.
6. **Part III**: This section must be completed by the Sponsoring Organization after Parts I and II are completed.
    a. **Accommodations Made**: The Sponsoring Organization staff will indicate what accommodations will be made for the requests made in Part II. All non-medical food substitutions served must meet meal pattern in order to be reimbursable.
    b. **Sponsor Signature and Date**: The Sponsoring Organization staff will sign and date the form. This form will be considered incomplete if this section is not filled in.

This form is only for non-medical meal preference requests and accommodations are subject to policies set by the Sponsoring Organization. Participants requiring a medical meal accommodation should be provided with a Medical Statement to be filled out by a licensed medical professional.