

Meal Preference Request Form

Child Care Provider Name:	Submit this form to: Nutrition First CACFP 2475 Center St NE Salem, OR 97301
----------------------------------	---

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

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:		
Bettergoods Original Soy Milk	Your Good Foods Organic Soy Milk	
Ripple Kids Pea Milk, Original or Unsweetened	Silk Protein Soy Milk	
Kikkoman Pearl Organic Smart Original Soy Milk	Silk Original Soy Milk (Red Box)	
Sunrich Natural Organic Soy Milk (Plain)	Silk Unsweet Soy Milk (Red Box)	
☐ 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 Use Only

Accommodation(s) Made: _____	

Sponsor Signature: _____	Date: _____

Instructions for completing the Meal Preference Request Form:

1. **Organization Name:** The name of the Sponsoring Organization (Nutrition First) that is providing the form
2. **Provider Name:** Print the name of the Child Care Provider who will be serving the meals. (Not the business name)
3. **Submit this form to: Nutrition First, 2475 Center St NE, Salem, OR 97301**
4. **Part I:** This section can be completed by the **Parent/Guardian or Organization**
 - a. **Name of Participant:** Print the first and last name of the child
 - b. **Parent/Guardian Name:** Print the first and last name(s) of the parent or guardian.
 - 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** (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.