FOOD SUBSTITUTION

Child Legal Name: _____ Program Term: _____

Center: _____ Classroom: _____FSW_____

- ☐ ***Check box if Epi Pen is required.***
- ☐ Food/Drink substitution request due to diet, religion, cultural, or ethical reasons.
- ☐ Parent preference or parent suspects food/drink allergy.
- ☐ Food /Drink allergy *diagnosed* by a Medical Professional.

Medical diagnosis (dietary related if any): _____

Food allergy, intolerance, or dietary restriction: _____

_____

Food(s) or drink(s) to be omitted: _____

_____

Reaction that occurs if any (please specify if occurs upon consumption or exposure)

☐ Mild ☐ Moderate ☐ Severe ☐ Life Threatening

_____

_____

Recommendations and possible food/drink substitutions:

_____

_____

_____

_____

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☐ Physician signature required if this box is checked (by EC Nurse)

_____ _____

Physician's Signature Date

_____ _____

Parent Signature Date

_____ _____

Early Childhood Nurse Date

- ☐ Training required for staff before child begins school. _____
- ☐ Training Provided by/Date: _____
- ☐ Staff Initials/Date: _____

SUBSTITUTO DE COMIDA

Nombre Legal del Niño: _____ Termino del Programa: _____

Centro: _____ Salón: _____ FSW_____

☐ ***Marque esta casilla si se requiere un Epi Pen.***

☐ Sustituto para la sustitución de Comida/Bebida por razones de dieta, religión, cultura o éticas.

☐ Preferencia de padres o el padre sospecha de una alergia la comida/bebida.

☐ Alergia a Comida/Bebida *diagnosticada* por un Profesional Médico.

Diagnóstico Médico (relacionada a la dieta si es que hay): _____

Alergia a Comida, intolerancia o restricción dietética. _____

_____

Comida(s) o bebida(s) que se deben omitir: _____

_____

Reacción que ocurre si ay alguna (por favor especifique que ocurre al consumir o ser expuestos)

☐ Leve ☐ Moderado ☐ Severo ☐ Potencialmente mortal

_____

_____

Recomendaciones y posibles sustitutos de comida/bebida:

_____

_____

_____

_____

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☐ La firma del Medico es requerida si esta casilla está marcada (por EC Nurse)

_____ _____

Firma de Medico Fecha

_____ _____

Firma de Padre Fecha

_____ _____

Enfermera de Early Childhood Fecha

□ Se requiere entrenamiento para el personal antes de que el niño empiece clases. _____

□ Entrenamiento proporcionado por/Fecha: _____

□ Iniciales del Personal/Fecha: _____

Name of Form: FOOD SUBSTITUTION

Purpose: This form is to be used to modify food served to children related to a food allergy, medical condition, or severe allergic reaction (anaphylaxis)for the safety of the child. It is also to be used to modify food served to children related to a caregiver's request for specialized diets/sensitivities/intolerances such as vegan, religious, cultural, or ethical reasons.

Instructions: **Diagnosed by a Medical Professional**: The Food Substitution form will be sent out to parents with their acceptance letter if the form needs to be completed by a Medical Professional at the time of their physical exam. ***A child must have this in place prior to starting school if it needs to be signed by a medical professional.*** (Physician, physician assistant, nurse practitioner, registered dietitian)

Food/Drink substitution request due to diet, religion, cultural, or ethical. reasons and Parent preference or parent suspects food/drink allergy: This form is to be completed by the parent.
**A parent who reports their child is lactose intolerant will need to specify what they want as a substitution or omission. Clarify with the parent if the intolerance is to dairy or protein.*
Reminder: Staff can *NEVER* sign or initial for a parent/guardian/client. If a missed signature occurs – make every effort possible to reach out and collect the signature from the parent/guardian/client.

Once this is completed and signed by the necessary professional, if needed, the FSW will scan it to the EC nurse email for review and signature. The Health Specialist will enter the information in on ChildPlus. If a Medical Professional signed the form, an Food Allergy Event will be created on ChildPlus.

Once the staff receives the signed copy by the Early Childhood Nurse, it is to be reviewed with all staff. Staff will initial and date the form. If training was provided, this form will be returned to the Health Specialist.

A copy will be posted in the food service area. Staff will make sure the food being omitted and the child's name is labeled on the table with a piece of tape or on a table tent and placed at the table where the child sits at mealtimes.

When a child needs a substitution, this needs to be reflected on the Daily Production Record (DPR). If it involves complicated substitutions, an RD may be required to review the menus and make the substitutions for up to three months or until the staff feel comfortable.

Completed By: Medical Professional, (if needed) / Early Childhood Nurse / FSW
Date Due: Prior to child attending class as needed.
Send To: Electronically to Early Childhood Nurse and Food Service Coordinator
Filed At: CACFP binder.
Posted: In Kitchen