MARINE CORPS COMMUNITY SERVICES
PSC 561 BOX 1867
FPO AP 96310-0029

DSN FAX: 253-6626
COMMERCIAL: 011-81-827-79-3070
DSN: 253-3070

Place

Picture here

Nutritional Plan for Children with Special Needs

Child's Name: _____

DOB: _____ Age: _____

Name of the MCCS Facility your child attends: _____Classroom Name: _____

Parent/Guardian requests exclusion of the following food(s): _____ based on religious beliefs.

***If the child does not require special meals, the parent can sign at the bottom and return the form to the Resource and Referral Office, bldg 637.

To be completed by **Medical Provider**:
Identify and describe disability or medical condition, including allergies, which require the child to have a special diet. Describe the major life activities affected by the child's disability.

_____

_____

_____

_____

Diet Prescription (check all that apply):

☐ Diabetic (Include calorie level, carbohydrate count and/or attach meal plan):

☐ Modified Texture and/or Liquids

☐ Reduced Calorie: ☐ Increased Calorie:

☐ Other (describe e.g. PKU, Ketogenic, Tube Feeding):

☐ **Food Allergies:** _____

☐ **Food Intolerance:** _____

When the dietary substitution is normally found in the child care center, and does not require additional expense, the program will provide the food. It is the parent's responsibility to make appropriate substitutions when the child care center cannot provide an adequate substitution.

Food Omitted and Substitutions: Use space to list specific food(s) to be omitted and food(s) that may be substituted. Describe in detail allergies e.g. milk allergy – does that include pudding, cheese, yogurt, etc.

OMITTED FOODS	SUBSTITUTIONS
_____	_____
_____	_____
_____	_____

You may attach an additional sheet if necessary.

☐ **Foods Requiring Texture Modifications:**

_____

_____

Indicate Texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed
Indicate Thickness of Liquids ☐ Regular ☐ Nectar ☐ Honey ☐ Pudding

☐ **Special Feeding Equipment:**

_____

_____

Additional Comments:

_____

_____

_____

_____

I certify that the above named child needs special meals as described above, due to the child's disability or chronic medical condition.

_____ _____ _____

Medical Provider's Signature **Telephone Number** **Date**

I hereby give my permission for the MCCS CDC or FCC or YC staff to follow the above stated nutrition plan.

_____ _____ _____

Parent/Guardian Signature **Telephone Number** **Date**