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**Model Ordinance: Healthy Beverages in Children’s Meals**

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**Introduction**

Today, one-third of US children and adolescents are obese or overweight.[[1]](#endnote-1) Overweight children are at increased risk for serious health problems in adulthood, including heart disease, type 2 diabetes, asthma, and cancer.[[2]](#endnote-2) The costs of obesity are high. Annual health care costs from obesity are at least $190 billion[[3]](#endnote-3)—or 21% of total health care spending—and are expected to rise substantially.[[4]](#endnote-4) Roughly 40% of these costs are paid through Medicare and Medicaid, which means that taxpayers foot much of the bill.[[5]](#endnote-5)

Sugary drinks play a crucial role in the obesity epidemic. A 2010 study found that sugary drinks—including soda, energy and sports drinks, sweetened water, and fruit drinks—were the largest source of daily calories in the diets of US children ages 2-18.6 Soda alone was the third largest source.[[6]](#endnote-6) In addition, each extra serving of a sugary drink consumed per day increases a child’s chance of becoming obese by 60%.[[7]](#endnote-7) Sugary drinks are also linked to other health problems. Sugary drink consumption is associated with a greater risk of cardiovascular disease in adolescents;[[8]](#endnote-8) increased risk of high blood pressure in adolescents;[[9]](#endnote-9) dental caries (cavities);[[10]](#endnote-10) and inadequate intake of nutrients, including calcium, iron, folate, magnesium, and vitamin A.[[11]](#endnote-11) Finally, the disparities in obesity rates by income and race and ethnicity mirror sugary drink consumption. African Americans and Mexican Americans of both sexes and across most age groups report consuming more sugary drink calories than whites.[[12]](#endnote-12)

Restaurants play a central role in the diet of Americans. Children consume almost 20% of their daily calories at fast-food and other restaurants.[[13]](#endnote-13) Children and adolescents who eat at fast-food restaurants—as well as those who eat at full-service restaurants—consume more sugary drinks and soda and less milk.[[14]](#endnote-14)

Restaurants have traditionally offered soda as the default beverage in children’s meals. A default is the preselected option that people receive if they do not explicitly choose something else. Requiring restaurants to provide healthier beverages in children’s meals is an effective way to improve the nutritional quality of children’s meals. The Walt Disney Company moved to this practice at its worldwide resorts and reported in 2008 that at its US resorts, 68% of beverage orders included the default healthier option.[[15]](#endnote-15)

**Model Ordinance**

*Model Ordinance: Healthy Beverages in Children’s Meals* offers local governments a way to steer restaurants toward providing healthier options for children by requiring healthy beverages in children’s meals. The model ordinance requires default beverages in children’s meals to be water, nonfat or 1% milk, or 6-ounce servings of 100% juice. These beverage standards are based on the *Recommendations for Healthier Beverages* from the Robert Wood Johnson Foundation’s Healthy Eating Research program*.*[[16]](#endnote-16) The model ordinance offers 2 options for communities. Option 1 sets the specified healthy beverages as the only options in a children’s meal; consumers must separately order and pay for a different beverage if they want one. Option 2 sets healthy beverages as the default option in children’s meals but allows consumers to specifically request another beverage without having to pay for it separately.

**Enacting the Policy**

While state law regulates the health and sanitation of restaurants, many cities and counties have the authority to regulate aspects of restaurant operations by exercising their police power—the authority of government to regulate private conduct to protect and further the public’s health, safety, or general welfare. Many communities already regulate other aspects of restaurants through zoning and other laws. For instance, some communities have banned smoking or restricted the sale of foods containing artificial trans fats on restaurant premises.

Whether a local government has the authority to regulate restaurants—and, therefore, to implement this model ordinance—is usually determined by state law. It is important to consult state law to determine whether a local government has the police power to regulate restaurants. It is equally important to examine the state’s retail food code to identify provisions that would prohibit local regulation of restaurant operations or otherwise govern children’s meals. These laws may preempt or prohibit local regulation of children’s meals.

Although it has been designed as a local ordinance, this model can be adapted for other uses. In some states, a local board of health may be able to implement the policy. Cities and counties could also pass a resolution urging restaurants to adopt these nutrition standards, or they could use the standards as part of a healthy restaurant initiative. And restaurants or restaurant associations could choose to adopt the standards voluntarily. If advocates wish to pursue state-level legislation, ChangeLab Solutions has also developed *Model Statute: Healthy Beverages in Children’s Meals*.

The language in this model ordinance is designed to be tailored to the needs of an individual community. The text in *italics* provides different options or explains the type of information that needs to be inserted in the blank spaces in the ordinance. The comments provide additional information and explanation.

Model Ordinance: Healthy Beverages in Children’s Meals

An Ordinance of the [*City/County of \_\_\_\_\_*] Providing for Healthy Beverages in Children’s Meals in Restaurants and Amending the [*City/County*] Municipal Code.

The [*Municipality*] does ordain as follows:

**SECTION I.** **Findings.**

The [*City/County*] hereby finds and declares as follows:

(a) Over the past several decades, the obesity rate in the United States has more than doubled. According to the Centers for Disease Control and Prevention, roughly 40% of American adults are obese.[[17]](#endnote-17) In [*insert name of city/county*], [*insert city/county’s percentage of obese adults here*] of adult residents are obese. About 1 in 5 children nationwide is obese.17 In [*insert name of city/county*], [*insert city/county’s percentage of obese youth here*] of children are obese. Obese children are at least twice as likely as non-obese children to become obese adults.[[18]](#endnote-18)

(b) Obese children and adults are at greater risk for numerous adverse health consequences, including type 2 diabetes, heart disease, stroke, high blood pressure, high cholesterol, certain cancers, asthma, low self-esteem, depression, and other debilitating diseases.[[19]](#endnote-19)

(c) Obesity-related health conditions have serious economic costs. Estimated annual health care costs from obesity in the United States are $190 billion[[20]](#endnote-20)—or 21% of total health care spending—and are expected to rise substantially.[[21]](#endnote-21) Roughly 40% of these costs are paid through Medicare and Medicaid, which means that taxpayers foot much of the bill.[[22]](#endnote-22) Obesity-related annual medical expenditures in [*insert name of city/county*] are estimated at [*insert city/county’s cost of obesity here*].[[23]](#endnote-23)

(d) [*Insert name of city/county*] has invested considerable resources to combat childhood obesity. [*Briefly summarize efforts of city/county*.]

(e) Sugary drinks play a crucial role in the obesity epidemic. Sugary drinks—including soda, energy and sports drinks, sweetened water, and fruit drinks—are the largest source of daily calories in the diet of US children ages 2-18.[[24]](#endnote-24) Each extra serving of a sugary drink consumed per day increases a child’s chance of becoming obese by 60%.[[25]](#endnote-25) Sugary drinks are also linked to other health problems, including a greater risk of cardiovascular disease in adolescents,[[26]](#endnote-26) higher blood pressure in adolescents,[[27]](#endnote-27) dental caries (cavities),[[28]](#endnote-28) and inadequate intake of nutrients, including calcium, iron, folate, magnesium, and vitamin A.[[29]](#endnote-29)

(f) Families in [*insert name of city/county*] have limited time to obtain and prepare healthy food, making dining out an appealing and often necessary option. Nationwide, US children eat 19 % of their calories at fast-food and other types of restaurants.[[30]](#endnote-30) [*Add local statistics on eating out, if available*.] Children and adolescents who eat at fast-food restaurants—as well as those who eat at full-service restaurants—drink more sugary drinks and soda and less milk.[[31]](#endnote-31)

1. Requiring restaurants to provide a healthy beverage as the default beverage automatically included in children’s meals is an effective way to improve the nutritional quality of children’s meals. The Walt Disney Company moved to this practice at its worldwide resorts and reported in 2008 that 68% of beverage orders at its US resorts included the default healthier option.[[32]](#endnote-32)

(h) By enacting this ordinance, [*insert name of* *city/county*][*insert type of* *legislators (eg, councilmembers, supervisors)*] intend to support parents’ efforts to feed their children healthfully by ensuring that healthy beverages are available to children in restaurants.

**COMMENT:** New legislation created by cities and counties usually includes factual “findings” that support the purposes of the legislation. The findings section is part of the ordinance and the legislative record, but it usually does not become codified in the municipal code. The findings contain factual information that supports the need for the law and explains its benefits. A city or county may select findings from this list to include in their legislation or may include different or additional findings that address the specific conditions in their community.

In addition to serving an educational purpose and building support for the ordinance, the findings can also serve a legal purpose. If the ordinance is challenged in court, the findings are an admissible record of the factual determinations made by the legislative body when considering the ordinance. Courts will generally defer to legislative determinations of factual issues, which often influence legal conclusions. Jurisdictions may include additional findings on local or regional conditions, outcomes, and issues that help make the case for the law.

**SECTION II.** [*Article/Chapter*] [*number of article or chapter*] of the [*City/County*] Municipal Code is hereby amended to read as follows:

**Section \_\_\_1. Purpose.** The purpose of this [*article/chapter*] is to support children’s health by requiring that healthy beverages be included in children’s meals at restaurants.

**Section \_\_\_2. Definitions.** The following words and phrases, whenever used in this [*article/chapter*], shall have the meanings defined in this section:

(a) “Children’s Meal” means a combination of 1 or more food items and a beverage, sold together at a single price, primarily intended for consumption by children.

(b) “Default Beverage” means the beverage automatically included as part of a Children’s Meal *[, absent a specific request by the purchaser of the Children’s Meal for an alternative beverage]*.

**Comment:** As described in the Introduction, this model ordinance offers 2 options. Option 1 sets the specified healthy beverages as the only options in a children’s meal; consumers must separately order and pay for a different beverage. Option 2 sets the specified healthy beverages as the default options but allows consumers to specifically request that another beverage be included in the children’s meal at no extra cost. The phrase in italics in subsection (b) directly above should be included in the ordinance if the community selects Option 2.

(c) “Restaurant” means a retail food establishment that prepares, serves, and sells food directly to consumers.

**Comment:** The definition of “Restaurant” is adapted from the definition of a food establishment in the US Food and Drug Administration’s *Food Code**,* a federal model for food regulations. Localities should use an existing definition from their municipal or state code.

**Section \_\_\_3. Beverages in Children’s Meals.**

(a) A Restaurant may not sell a Children’s Meal unless the Default Beverage is one of the following:

(1) Water, sparkling water, or flavored water, with no added natural or artificial sweeteners;

(2) Nonfat or 1% milk;

(3) A non-dairy milk alternative containing no more than 130 calories per container and/or serving as offered for sale; or

*[(4) 100% juice, with no added sweeteners, in a serving size of no more than 6 ounces.]*

**Comment**: The beverage standards are based on *Recommendations for Healthier Beverages* from the Robert Wood Johnson Foundation’s Healthy Eating Research Project.[[33]](#endnote-33) Some localities may decide not to include juice.

*[(b) Nothing in this section prohibits a Restaurant from selling, or a customer from purchasing, a beverage other than the Default Beverage included with a Children’s Meal, if the customer requests the substitute or alternative beverage.]*

**Comment**: The optional language in subsection (b) directly above should be included in the ordinance if the community selects Option 2, which sets the specified healthy beverages to be included the default order but allows consumers to request that another beverage be included in the children’s meal.

**Section \_\_\_4. Enforcement.**

(a) The [*name of* *agency, department, or official*] shall implement, administer, and enforce this [*article/chapter*]. The[*name of* *agency, department, or official*] is hereby authorized to issue all rules and regulations consistent with this [*article/chapter*] and shall have all necessary powers to carry out the purpose of this [*article/chapter*].

(b) In addition to all other available remedies at law, this [*article/chapter*] shall be enforceable through *[add references to the city’s administrative citation procedures and other applicable enforcement mechanisms]*.

*[(c) All Restaurants shall report, upon enactment of this [article/chapter] and annually thereafter, to [name of agency, department, or official charged with enforcement of this ordinance] whether they offer Children’s Meals and if so, what beverages they offer as Default Beverages, as defined in this [article/chapter], in Children’s Meals. Such reporting must be done on a form prescribed by the [name of agency, department, or official charged with enforcement of this ordinance] and must be signed by a responsible agent or officer of the Restaurant in order to confirm that the information provided on the form is accurate and complete. Failure to comply with this subsection shall constitute a violation of this [article/chapter].]*

**Comment**: The enforcement clauses above should be tailored to meet the needs of the particular community. Municipalities have a variety of ways to enforce ordinances. Language should be added to reference existing enforcement procedures. The City of Davis, California, which has a healthy default beverage ordinance, has adopted a self-certification process. Subsection (c) above provides language for a self-certification process.

**Section \_\_\_5. Effective Date.**

The provisions of this ordinance shall become effective on [*insert date up to 6 months from the enactment of the ordinance*].

**Comment**: The enforcement agency—likely the department of health—will require time to educate local restaurants about the new law. Restaurants will also require time to conform their practices to the new law. Accordingly, we suggest that the municipality allow up to 6 months between enactment and the ordinance’s effective date.

**SECTION III. Statutory Construction & Severability.**

This [*article/chapter*] shall be construed so as not to conflict with applicable federal or state laws, rules, or regulations. Nothing in this [*article/chapter*] authorizes any agency to impose any duties or obligations in conflict with limitations on [*municipal/county*] authority established by federal or state law at the time such agency action is taken.

In the event that a court or agency of competent jurisdiction holds that federal or state law, rule, or regulation invalidates any clause, sentence, paragraph, or section of this [*article/chapter*] or the application thereof to any person or circumstance, it is the intent of the [*specify local legislative body* *(eg, City Council)*] that the court or agency sever such clause, sentence, paragraph, or section so that the remainder of this [*article/chapter*] remains in effect.

1. Ogden CL, Carroll MD, Kit BK, et al. Prevalence of childhood and adult obesity in the United States, 2011-2012. *JAMA.* 2014;311(8):806-814. [jama.jamanetwork.com/article.aspx?articleid=1832542](https://jama.jamanetwork.com/article.aspx?articleid=1832542)*.* [↑](#endnote-ref-1)
2. U.S. Department of Health and Human Services, Office of the Surgeon General. *The Surgeon General’s Call to* *Action to Prevent and Decrease* *Overweight and Obesity*. Rockville, MD: Office of the Surgeon General (US); 2001. [ncbi.nlm.nih.gov/books/NBK44206/](http://www.ncbi.nlm.nih.gov/books/NBK44206/); Food and Nutrition Board and Board on Health Promotion and Disease Prevention. *Preventing Childhood Obesity: Health in the Balance*. Washington, DC: The National Academies Press; 2005:67-69. [books.nap.edu/openbook.php?record\_id=11015&page=67](http://books.nap.edu/openbook.php?record_id=11015&page=67). [↑](#endnote-ref-2)
3. Cawley J, Meyerhoefer C. The medical care costs of obesity: an instrumental variables approach. *J Health Econ.* 2012;31(1):219-230. [↑](#endnote-ref-3)
4. Wang YC, McPherson K, Marsh T, Gortmaker SL, Brown M. Health and economic burden of the projected obesity trends in the USA and the UK. *Lancet.* 2011;378:815-825. [↑](#endnote-ref-4)
5. Trogdon JG, Finkelstein EA, Feagan W, Cohen JW. State- and payer-specific estimates of annual medical expenditures attributable to obesity. *Obesity.* 2012;20:214-220. [↑](#endnote-ref-5)
6. Reedy J, Krebs-Smith SM. Dietary sources of energy, solid fats, and added sugars among children and adolescents in the United States. *J Am Diet Assoc.* 2010;110:1477-1484. [↑](#endnote-ref-6)
7. Ludwig DS, Peterson KE, Gortmaker SL. Relation between consumption of sugar-sweetened drinks and childhood obesity: a prospective, observational analysis. *Lancet.* 2001;357:505-508. [↑](#endnote-ref-7)
8. Welsh JA, Sharma A, Cunningham SA, Vos MB. Consumption of added sugars and indicators of cardiovascular disease risk among US adolescents. *Circulation.* 2011;123:249-257. [↑](#endnote-ref-8)
9. Nguyen S, Choi HK, Lustig RH, Hsu C. Sugar-sweetened beverages, serum uric acid, and blood pressure in adolescents. *J Pediatr.* 2009;154:807-813. [↑](#endnote-ref-9)
10. Ismail AI, Sohn W, Lim S, Willem JM. Predictors of dental caries progression in primary teeth. *J Dent Res.* 2009;88:270-275. [↑](#endnote-ref-10)
11. Ballew C, Kuester S, Gillespie C. Beverage choices affect adequacy of children’s nutrient intakes. *Arch Pediatr Adolesc Med.* 2000;154(11):1148-1152. [archpedi.jamanetwork.com/article.aspx?articleid=352051](http://archpedi.jamanetwork.com/article.aspx?articleid=352051); see also Kranz S, Smicklas-Wright H, Siega-Riz AM, et al. Adverse effect of high added sugar consumption on dietary intake in American preschoolers. *J Pediatr.* 2005;146(1):105-111. Abstract available at [ncbi.nlm.nih.gov/pubmed/15644832](http://www.ncbi.nlm.nih.gov/pubmed/15644832); Marshall TA, Eichenberger-Gilmore JM, Broffit B, et al. Diet quality in young children is influenced by beverage consumption. *J Am Coll Nutr.* 2005;24(1):65-75. Abstract available at [ncbi.nlm.nih.gov/pubmed/15670987](http://www.ncbi.nlm.nih.gov/pubmed/15670987). [↑](#endnote-ref-11)
12. U.S. Department of Agriculture. *Materials from the Sixth Meeting of the 2010 Dietary Guidelines Advisory Committee, Additional Resources, Charts and Tables: Energy from Sugar-Sweetened Beverages*. Alexandria, VA: Center for Nutrition Policy and Promotion; 2010.[fns.usda.gov/resource/dietary-guidelines-americans-reports-publications](https://www.fns.usda.gov/resource/dietary-guidelines-americans-reports-publications) See also Kumanyika S, Grier SA, Lancaster K, et al. *Impact of Sugar-Sweetened Beverage Consumption on Black Americans’ Health*. Philadelphia, PA: African American Collaborative Obesity Research Network, University of Pennsylvania; 2011. [rwjf.org/content/dam/farm/reports/reports/2011/rwjf69184](http://www.rwjf.org/content/dam/farm/reports/reports/2011/rwjf69184); Taveras EM, Gilman MW, Kleinman K, et al. Racial/ethnic differences in early-life risk factors for childhood obesity. *Pediatr.* 2010;125(4):686-695. [pediatrics.aappublications.org/content/125/4/686.full.pdf+html](http://pediatrics.aappublications.org/content/125/4/686.full.pdf%2Bhtml). [↑](#endnote-ref-12)
13. Lin BH, Morrison RM. *Food and Nutrient Intake Data: Taking a Look at the Nutritional Quality of Foods Eaten at Home and Away from Home*. Washington, DC: Economic Research Service, U.S. Department of Agriculture; 2012. [ers.usda.gov/amber-waves/2012/june/data-feature-food-and-nutrient-intake-data.aspx](http://www.ers.usda.gov/amber-waves/2012/june/data-feature-food-and-nutrient-intake-data.aspx). [↑](#endnote-ref-13)
14. Powell LM, Nguyen BT. Fast-food and full-service restaurant consumption among children and adolescents: effect on energy, beverage, and nutrient intake. *JAMA Pediatr.* 2013;167(1):14-20. doi:10.1001/jamapediatrics.2013.417. [↑](#endnote-ref-14)
15. *The Walt Disney Company 2008 Corporate Responsibility Report.* Burbank, CA: The Walt Disney Company; 2008;19, chart 6.
[ditm-twdc-us.storage.googleapis.com/FY08Disney\_CR\_Report\_2008.pdf](http://ditm-twdc-us.storage.googleapis.com/FY08Disney_CR_Report_2008.pdf). [↑](#endnote-ref-15)
16. Healthy Eating Research. *Recommendations for Healthier Beverages*. Princeton, NJ: Robert Wood Johnson Foundation; March 2013. [rwjf.org/content/dam/farm/reports/issue\_briefs/2013/rwjf404852](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404852)*.* [↑](#endnote-ref-16)
17. Hales CM, Carroll MD, Fryar CD, Ogden CL. *Prevalence of Obesity Among Adults and Youth: United States, 2015–2016*. Washington, DC: Centers for Disease Control and Prevention; 2017. [cdc.gov/nchs/products/databriefs/db288.htm](https://www.cdc.gov/nchs/products/databriefs/db288.htm). [↑](#endnote-ref-17)
18. Serdula MK, Ivery D, Coates RJ, et al. Do obese children become obese adults? a review of the literature. *Prev Med.* 1993;22(2):167-177. [ncbi.nlm.nih.gov/pubmed/8483856](http://www.ncbi.nlm.nih.gov/pubmed/8483856). [↑](#endnote-ref-18)
19. Office of the Surgeon General; Office of Disease Prevention and Health Promotion; Centers for Disease Control and Prevention; National Institutes of Health. *The Surgeon General’s Call to* *Action to Prevent and Decrease* *Overweight and Obesity*. Rockville, MD: U.S. Department of Health and Human Services; 2001. [ncbi.nlm.nih.gov/books/NBK44210/](http://www.ncbi.nlm.nih.gov/books/NBK44210/). [↑](#endnote-ref-19)
20. Cawley J, Meyerhoefer C. The medical care costs of obesity: an instrumental variables approach. *J Health Econ.* 2012;31(1):219-230. [↑](#endnote-ref-20)
21. Wang YC, McPherson K, Marsh T, Gortmaker SL, Brown M. Health and economic burden of the projected obesity trends in the USA and the UK. *Lancet.* 2011;378:815-825. [↑](#endnote-ref-21)
22. Trogdon JG, Finkelstein EA, Feagan W, Cohen JW. State- and payer-specific estimates of annual medical expenditures attributable to obesity. *Obesity.* 2012;20:214-220. [↑](#endnote-ref-22)
23. For state-specific health care spending data, see Trogdon JG, Finkelstein EA, Feagan W, Cohen JW. State- and payer-specific estimates of annual medical expenditures attributable to obesity. *Obesity.* 2012;20:214-220. [↑](#endnote-ref-23)
24. Reedy J, Krebs-Smith SM. Dietary sources of energy, solid fats, and added sugars among children and adolescents in the United States. *J Am Diet Assoc.* 2010;110:1477-1484. [↑](#endnote-ref-24)
25. Ludwig DS, Peterson KE, Gortmaker SL. Relation between consumption of sugar-sweetened drinks and childhood obesity: a prospective, observational analysis. *Lancet.* 2001;357:505-508. [↑](#endnote-ref-25)
26. Welsh JA, Sharma A, Cunningham SA, Vos MB. Consumption of added sugars and indicators of cardiovascular disease risk among US adolescents. *Circulation.* 2011;123:249-257. [↑](#endnote-ref-26)
27. Nguyen S, Choi HK, Lustig RH, Hsu C. Sugar-sweetened beverages, serum uric acid, and blood pressure in adolescents. *J Pediatr.* 2009;154:807-813. [↑](#endnote-ref-27)
28. Ismail AI, Sohn W, Lim S, Willem JM. Predictors of dental caries progression in primary teeth. *J Dent Res.* 2009;88:270-275. [↑](#endnote-ref-28)
29. Ballew C, Kuester S, Gillespie C. Beverage choices affect adequacy of children’s nutrient intakes. *Arch Pediatr Adolesc Med.* 2000;154(11):1148-1152. [archpedi.jamanetwork.com/article.aspx?articleid=352051](http://archpedi.jamanetwork.com/article.aspx?articleid=352051); see also Kranz S, Smicklas-Wright H, Siega-Riz AM, et al. Adverse effect of high added sugar consumption on dietary intake in American preschoolers. *J Pediatr.* 2005;146(1):105-111. Abstract available at [ncbi.nlm.nih.gov/pubmed/15644832](http://www.ncbi.nlm.nih.gov/pubmed/15644832); Marshall TA, Eichenberger-Gilmore JM, Broffit B, et al. Diet quality in young children is influenced by beverage consumption. *J Am Coll Nutr.* 2005;24(1):65-75. Abstract available at [ncbi.nlm.nih.gov/pubmed/15670987](http://www.ncbi.nlm.nih.gov/pubmed/15670987). [↑](#endnote-ref-29)
30. Lin BH, Morrison RM. *Food and Nutrient Intake Data: Taking a Look at the Nutritional Quality of Foods Eaten at Home and Away from Home*. Washington, DC: Economic Research Service, U.S. Department of Agriculture; 2012. [www.ers.usda.gov/amber-waves/2012/june/data-feature-food-and-nutrient-intake-data.aspx](https://www.ers.usda.gov/amber-waves/2012/june/data-feature-food-and-nutrient-intake-data.aspx). [↑](#endnote-ref-30)
31. Powell LM, Nguyen BT. Fast-food and full-service restaurant consumption among children and adolescents: effect on energy, beverage, and nutrient intake. *JAMA Pediatr.* 2013;167(1):14-20. doi:10.1001/jamapediatrics.2013.417. [↑](#endnote-ref-31)
32. *The Walt Disney Company 2008 Corporate Responsibility Report.* Burbank, CA: The Walt Disney Company, 2008;19, chart 6. [ditm-twdc-us.storage.googleapis.com/FY08Disney\_CR\_Report\_2008.pdf](http://ditm-twdc-us.storage.googleapis.com/FY08Disney_CR_Report_2008.pdf). [↑](#endnote-ref-32)
33. Healthy Eating Research. *Recommendations for Healthier Beverages*. Princeton, NJ: Robert Wood Johnson Foundation; 2013. [rwjf.org/content/dam/farm/reports/issue\_briefs/2013/rwjf404852](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404852)*.* [↑](#endnote-ref-33)