

Child and Adult Care Food Program (CACFP)

MEDICAL STATEMENT FOR FOOD SUBSTITUTIONS

Part I: To be completed by parent, guardian, or adult day care participant, as applicable

Date: _____ **Participant's Name:** _____

Parent or Guardian's Name (if applicable):

Day Care Provider/Facility: _____

Part II: To be completed by a *Recognized Medical Authority*

Recognized Medical Authorities: Licensed Physicians (MD), Physician's Assistants (PA), Registered Dietitians (RD), Nurse Practitioners (NP), Registered Nurses (RN), Naturopathic Physician (NP), Doctor of Osteopathy (DO), and Naturopathic Doctor of Osteopathy (NDO).

Date: _____ **Patient/Client's Name:** _____

Medical Condition that requires participant to have food substitutions: _____

Food(s) to be omitted from diet:

Foods to be substituted:

I certify the above named patient/client requires the food substitutions described above for medical reasons:

Signature of Medical Authority _____