Child Care Food Program
Medical Statement for Meal Modifications

Child care facility staff must complete the following information.

Child’s Name: ______________________________________  Date: ______________________

Name of Child Care Facility: ___________________________________________________________________

Facility Address: ______________________________________ Phone Number: _________________________

Child Care Facility Director Name: ________________________________

Dear Parent/Guardian and Recognized Medical Authority:

Reasonable modifications must be made for children with disabilities that restrict their diet. A disability means any person who has a physical or mental impairment which substantially limits one or more “major life activities” including eating, digestion, and feeding skills. A physical or mental impairment does not need to be life threatening to constitute a disability. Examples of a disability may include diabetes, food allergy or intolerance, developmental delay, or autism.

When substitutions are made and the meal pattern is not met, a medical statement is required and must be signed by a physician, physician’s assistant (PA), or nurse practitioner (ARNP). Please return this completed form to the child care center. If you have any questions, please contact the facility.

A recognized medical authority must complete the following information.

Describe the physical or mental impairment that restricts the child’s diet:

________________________________________________________________________________________

Foods to be Omitted:                    Foods to be Substituted:
_____________________________________   __________________ ___________________
_____________________________________   __________________ ___________________
_____________________________________    _________________ ___________________

Describe any textural modification, adaptive equipment, or other modifications required:

________________________________________________________________________________________

______________________________  ___________ __________________
Signature of Physician or Recognized Medical Authority  Date
(For a disability – a Physician, PA, or ARNP must sign)

______________________________  ______________________
Printed Name         Phone Number

A parent or guardian must complete the following information.

☐ Check box if request is regarding a religious or dietary preference only (medical authority signature not required)

This facility has not requested or required me to provide special food(s) for my child. I understand that my child care facility is required to provide special food(s) for children with disabilities. Requests for modifications due solely to preference are encouraged but not required.

Parent Signature: ___________________________  Date: __________________

Printed Name of Parent: ___________________________  Parent Phone Number: _______________________

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