

**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:** \_\_\_\_\_  
\_\_\_\_\_

<p><b>Food(s) to be omitted from diet:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Foods to be substituted:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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I certify the above named patient/client requires the food substitutions described above for medical reasons:

**Signature of Medical Authority** \_\_\_\_\_