



State of Arizona
Department of Education

**CHILD & ADULT CARE FOOD PROGRAM
MEDICAL STATEMENT FOR PARTICIPANTS REQUIRING FOOD SUBSTITUTIONS**

Name of Participant:	Date of Birth:
Parent Name:	Parent Telephone Number:
Name of Center:	Telephone Number of Center:

Address of Center:

Dear Parent/Guardian:

This day care center participates in the Child and Adult Care Food Program (CACFP) and must serve meals and snacks meeting the CACFP requirements. Food substitutions may be made only when supported by a recognized medical authority. A recognized medical authority may include, but is not limited to a medical physician, registered nurse, or registered dietitian. The recognized medical authority must specify, in writing, an indication of the medical or other special dietary condition which restricts the participant's diet; the food to be omitted and the food or choice of foods that may be substituted. Please have a medical authority complete and sign this form. Return it to the center director upon completion.

1. Identify the medical or special dietary condition which restricts the participants diet:

The participant has the following disability as defined under Section 504 of the Rehabilitation Act or Part B of IDEA which requires food substitutions: _____

The participant has the following food allergy that may result in a severe, life-threatening (anaphylactic) reaction which therefore meets the definition of a disability and requires food substitutions: _____

The participant has the following food intolerance which does not meet the definition of a disability but it is preferred that certain foods be avoided: _____

2. Explain why the disability restricts the diet and the major life activity affected by the disability:

N/A Participant is not disabled

3. List the food or foods to be omitted from the diet and the food or foods that are to be substituted:

Foods to be omitted	Allowable Substitutions	Additional instructions, requirements, or modifications (such as special equipment, texture, thickness, etc.)

4. Certify that the participant must be provided the special diet or accommodations indicated above:

Printed Name	Title
Signature	Date