MEDICAL STATEMENT FOR PARTICIPANTS WITH SPECIAL DIETARY NEEDS

To be completed by a Parent, Guardian, or Authorized Representative		
Participant's Name:		**Birthday:**
Parent/Guardian/Authorized Representative name:		
Home Phone: ( )		**Work Phone: ( )**
Address:		
City:	**State:**	**Zip:**

☐ Participant has a disability or medical condition and requires a special meal or accommodation. **(*Recognized Medical Authority must sign)**

☐ Participant **does not** have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. (Substitutions made at the discretion of the center.) (***Recognized Medical Authority must sign)**

☐ Participant **does not** have a disability, but is requesting a special accommodation for a fluid milk substitute that meets the nutrient standards for non-dairy beverages offered as milk substitutes. **(Substitutions made at the discretion of the center.)**

A non-dairy beverage product must at a minimum contain the following nutrient levels per cup to qualify as an acceptable milk substitution.		
a. Calcium 276 mg b. Protein 8 g c. Vitamin A 500 IU	d. Vitamin D 100 IU e. Magnesium 24 mg f. Phosphorus 222 mg	g. Potassium 349 mg h. Riboflavin .44 mg i. Vitamin B-12 1.1 mcg

Foods to be omitted:	**Substitutions:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Please list foods and information regarding any needed texture changes (chopped, ground, pureed, etc.):

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Please provide any other information regarding the diet:

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Recognized Medical Authority: Anyone who can prescribe medication.

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Physician/Medical Authority's Signature **Date**

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Printed Name and Title **Telephone**

**7 CFR 226.20 (h) & Policy Memo: CACFP 13-2015*