

**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** \_\_\_\_\_