Institution/Sponsor Name: _____ Agreement Number: _____

Facility Name: _____

Child and Adult Care Food Program (CACFP)
Summer Food Service Program (SFSP)
Medical Statement for CACFP and SFSP Participants
Requiring Meal Modifications

Dear Parent/Guardian:
This institution/sponsor participates in the Child and Adult Care Food Program (CACFP) and/or the Summer Food Service Program (SFSP) and must serve meals and snacks meeting the CACFP and/or SFSP requirements. If a participant has a documented disability that restricts his/her diet, the institution/sponsor is required to provide substitutions as identified by a Licensed Physician. If a participant has a documented medical condition that restricts his/her diet, institution/sponsor must have a medical statement from a Licensed Physician or Recognized Medical Authority (Physician's Assistant or Nurse Practitioner), the institution/sponsor at their discretion may provide the substitution. Please have your Physician or Recognized Medical Authority complete and sign this form. Return the completed form to this institution/sponsor.

Participant Information		
1. Name:	2. DOB:	
Disability or Medical Condition		
3. The participant has a disability which restricts his/her diet: **If yes is checked, complete numbers 5 – 9**	☐ Yes	☐ No
4. The participant has a medical condition that restricts his/her diet: **If yes is checked, complete numbers 5, 8-9**	☐ Yes	☐ No
5. What is the disability/medical condition requiring modification of meals?		
6. Explain why disability restricts participant's diet:		
7. Major life activity affected by disability: (Check all that apply) ☐ caring for one's self ☐ performing manual tasks ☐ walking ☐ seeing ☐ hearing ☐ speaking ☐ breathing ☐ learning ☐ working		

Substitutions	
8. Identify Foods to Omit from Diet:	**9. Identify Foods that may be Substituted in Diet:**

Other Special Dietary Needs		
10. The participant requires caloric modifications:	☐ Yes	☐ No
11. If yes, provide the caloric modification: _____ calories per day		
12. Other therapeutic diets (please explain):		
For participant with a disability (If number 3 is checked yes, this form must be signed by a physician)		
13.Signature of Physician:	**Date:**	
For non-disabled participant		
14. Signature of Recognized Medical Authority:	**Date:**	