

**Child and Adult Care Food Program
MEDICAL EXCEPTION STATEMENT FOR FOOD SUBSTITUTION**

CHILD'S NAME

DATE

NAME OF DAY CARE CENTER/HOME AND ADDRESS

Dear Parent/Guardian:

This day care center/home 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 physician's statement. Please ask your physician to complete and sign this form. Return the completed form to the day care center/home. If you have any questions, please contact me at _____.

Day Care Center/Home Phone Number

Sincerely,

Day Care Center/Home Contact Person

CACFP SPONSOR - KEEP COMPLETED FORM SIGNED BY PHYSICIAN ON FILE AT THE DAY CARE CENTER/HOME

COMPLETE ALL INFORMATION

1. Does child have a disability according to 7 CFR Part 15b.3 (*defined as "any person who has a physical or mental impairment which substantially limits one or more major life activities"*)?

- YES **If yes, provide the following information and complete parts 3, 4 and 5.**
 NO **If no, go to part 2.**

- a. What is the disability? _____
b. How does the disability restrict the diet? . _____
c. What major life activity is affected? _____

2. Child has no disability but requires a special diet.
Provide the following information and complete parts 3, 4 and 5.
Identify medical problem which restricts the child's diet.

3. List food/type of food to be omitted.

4. List food/type of food to be substituted.

5. _____
Date



Signature of Physician