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:**

Instructions are on the reverse side.

An Equal Opportunity Employer

Instructions

Participant Information:

1. Provide the name of the participant who needs the modified meal
2. Provide the date of birth of the participant

Disability (formerly known as Handicapped Participant) or Medical Condition

7 CFR Subtitle A, Section 15b.3(i) Definitions:

(i) *A person with a "disability"* means any person who has a "physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment."

3. The participant has a disability which restricts his/her diet: Check one. If yes is checked, complete numbers 5 through 9.
4. The participant has a medical condition that restricts the participant's diet: Check one. If yes is checked, complete numbers 5, 8 through 9.
5. Briefly describe the disability or medical condition that necessitates the meal modification.
6. If the condition is a disability, explain why disability restricts participant's diet.
7. If the condition is a disability, indicate which major life activity is affected by disability. Check all major life activities that are affected by the disability. If the medical condition is not a disability leave this section blank.

Substitutions:

8. List the foods that must not be served to this participant.
9. For each food that must be omitted from the participant's diet list an alternate substitute that the participant is able to consume.

Other Special Dietary Needs:

10. Indicate whether the meal modification requires a caloric adjustment.
11. Indicate the type of caloric modification needed for the participant.
12. If the meal modification relates to a therapeutic diet or texture modification, please explain.

Health Care Provider Information:

13. If the meal modification is for a person with a disability, the institution/sponsor is required to make the modification and the form must be signed and dated by a physician.
14. If this meal modification is due to a medical condition not constituting a disability, the institution/sponsor is encouraged to make the substitution and the form must be signed and dated by a Recognized Medical Authority. (Physician, Physician Assistant, Nurse Practitioner)