



The Child and Adult Care Food Program

**Medical Substitution Form**  
**Statement for Special Diet Prescription**

The following child is a participant in the United States Department of Agriculture (USDA) Child Care component of the CACFP. USDA regulation 7CFR Part 226.20(h) requires substitution or modifications in program meals for children with special dietary needs or disabilities restrict their diets. A child with a disability must be supplied substitutions for foods when that need is supported by a statement signed by a licensed physician. Food allergies which may result in severe, life-threatening (anaphylactic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physician/medical authority would be made. The statement must include the following:

**Part 1: To be completed by Parent/Caregiver**

Child's Name:		Date of Birth:	Gender (circle): M      F
Name of School/Center/Program/Provider:		Grade Level/Classroom (if applicable):	
Name of Caregiver/Guardian		<p>In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act I hereby authorize (physician/medical authority name: _____) to release such protected health information as is necessary for the specific purpose of Special Diet information to (Program Name: _____) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on (Date: _____). This information is to be released for the specific purpose of Special Diet information.</p> <p>The undersigned certifies that he/she is the parent, guardian or authorized representative of the child listed on this document and has the legal authority to sign on behalf of that child.</p> <p>Parent/Guardian Signature: _____</p> <p>Date: _____</p>	
Home Phone:	Work Phone:		
Street Address:			
City, State, Zip Code:			

**Part 2: To be completed by Physician/Medical Authority**

Recognized Medical Authorities: physician (MD), physician's assistant (PA), nurse practitioner (NP), registered nurse (RN), or registered dietitian (RD).

<p>Does the child have a disability?          Yes _____ No _____          If Yes, please describe the major life activities affected by the disability.</p>	<p>Does the child have special nutritional or feeding needs?          Yes _____ No _____          If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.</p>
<p>If the child is not disabled, does he/she have special nutritional or feeding needs?          Yes _____ No _____          If Yes, please complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.</p>	<p>Does the child require emergency medication be administered?          Yes _____ No _____          If yes, please list medication(s) and describe situation/reactions that would necessitate administering.</p>

**Part 3: To be completed by a Recognized Medical Authority**

Recognized Medical Authorities: physician (MD), physician's assistant (PA), nurse practitioner (NP), registered nurse (RN), or registered dietitian (RD).

List any dietary restrictions or special diet:

List any food allergies or food intolerances:

List foods to be substituted (mandatory):

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All".

Cut up/chopped into bite sized pieces:

Finely Ground:

Pureed:

List any special equipment or utensils needed:

Indicate any other comments about the child's eating or feeding patterns:

Physician's Name and Office Phone Number:

Office Stamp

Physician's/Medical Authority Signature

Date

**Part 4: Parent or Guardian Signature**

Parent or Guardian Signature

Date

**Part 5: Program Official Signature**

Program Official Signature

Date

\*Please have parent/guardian review form annually and initial/date if no changes are required.  
Any changes require submission of a new form signed by the Physician/Medical Authority.