MEDICAL STATEMENT FOR PARTICIPANTS WITH A DISABILITY ENROLLED IN THE CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

This Medical Statement is **ONLY** for a participant **with a disability** that affects their diet and should **NOT** be used for children with lactose *intolerance*. This form must be:

- Thoroughly completed and signed by a licensed physician
- Submitted to the child care before any meal modifications will be made
- Updated whenever the participant's diagnosis or special diet changes

PART 1: PARTICIPANT'S INFORMATION: parent or guardian must complete - please PRINT

_____ _____

Participant's Name: Last / First / Middle Initial Date of Birth

_____

Parent/Guardian Signature Today's Date

PART 2: DIET ORDER: a licensed physician must complete this portion - please PRINT

_____ The participant named above has a disability and requires a special diet or food accommodation

Yes

An individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the Americans Disability Act (ADA) as a person with a physical or mental impairment that substantially limits one or more major life activities, has a record as having such impairment. A major life activity means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

1. Identify the participant's disability: _____ AND/OR

   1a. Identify food allergy that is life-threatening/anaphylactic _____

_____

2. List the major life activities affected by the disability: _____

_____

3. Describe how the disability restricts the participant's diet: _____

_____

Part 3. DIETARY ACCOMODATION - must be completed by a licensed physician - list foods to be omitted and foods to be substituted and any other instructions.

Foods to be Omitted	Foods to be Substituted

Other dietary modification OR additional instructions (may attach specific diet order instructions):

_____

_____

_____

Part 4. SIGNATURE OF LICENSED PHYSICIAN

Licensed Physician Name & Credentials (Please PRINT) _____ Date _____

Licensed Physician Signature _____ Phone # _____

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington D.C. 20250-9410 or call toll free (866) 632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."