

**Special Diet Statement by Medical Authority** for a participant **without** a disability  
Enrolled in the Child and Adult Care Food Program

This Special Diet Statement is for a participant without a disability who is medically certified as having a special dietary need. Requests for a special diet must be:

- Supported by a Special Diet Statement that is thoroughly completed and signed by a recognized medical authority (e.g. licensed physician, physician's assistant, certified nurse practitioner, or licensed dietitian)
- Submitted to the child/adult care center before any meal modifications will be made

**Part 1. Participant Information – To be completed by parent/guardian**

Participant's Name Last/First/Middle Initial

Date of Birth

Parent/Guardian Signature

Home Phone

Work Phone

Today's Date

**Part 2: Participant Status - To be completed by Recognized Medical Authority**

**Food Intolerance:** Food(s) intolerant to:

The Child and Adult Care Food Program requires a **nutrient equivalent** non-dairy milk substitute be provided to participant's with a non-disabling medical condition. Juice and Water are **NOT** nutritionally equivalent to cow's milk and **cannot be used as a substitute**.

**Food Allergy:** Food(s) allergic to:

The participant's allergy to the food(s) stated above **does not** result in a life threatening reaction (anaphylactic). PLEASE NOTE: a food allergy is considered to be a disability when it falls within the following definition:

Definition of **handicapped person** from 7 CFR 15b.3:

- (i) Handicapped person 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 impairment.
- k) Major life activities means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

**Part 3. Dietary Accommodation - To be completed by the Recognized Medical Authority**

List specific foods to be omitted and foods to be substituted - please print

Foods to be Omitted	Foods to be Substituted

**Part 4. Signature of Recognized Medical Authority**

\_\_\_\_\_  
Name/Credentials (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Phone #

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