MEDICAL STATEMENT FOR PARTICIPANTS WITH SPECIAL DIETARY NEEDS

To be completed by a Parent, Guardian, or Authorized Representative		
Participant's Name:		**Birthday:**
Parent/Guardian/Authorized Representative name:		
Home Phone: ( )	**Work Phone: ( )**	
Address:		
City:	**State:**	**Zip:**

☐ Participant has a disability or medical condition and requires/requests a special meal or accommodation.
(*Recognized Medical Authority must sign)

☐ Participant **does not** have a disability, but is requesting a special accommodation for a fluid milk substitute that meets the nutrient standards for non-dairy beverages offered as milk substitutes.
(Substitutions made at the discretion of the center.)

A non-dairy beverage product must at a minimum contain the following nutrient levels per cup to qualify as an acceptable milk substitution.

a. Calcium 276 mg
b. Protein 8 g
c. Vitamin A 500 IU
d. Vitamin D 100 IU
e. Magnesium 24 mg
f. Phosphorus 222 mg
g. Potassium 349 mg
h. Riboflavin .44 mg
i. Vitamin B-12 1.1 mcg

Foods to be omitted:	**Substitutions:**
_____	_____
_____	_____
_____	_____

Please list foods and information regarding any needed texture changes (chopped, ground, pureed, etc.):

_____

_____

_____

Please provide any other information regarding the diet:

_____

_____

_____

Recognized Medical Authority: Anyone who can prescribe medication.

_____

Physician/Medical Authority's Signature **Date**

_____

Printed Name and Title **Telephone**

**7 CFR 226.20 (h) & Policy Memo: CACFP 13-2015*