

MEDICAL STATEMENT

PURPOSE: To obtain support documentation for Food Allergies/Required Food Component Substitutions

- **Parent:** Have the **physician/physician's assistant/nurse practitioner (ARNP), or registered dietitian** complete a Child Care Food Program Medical Statement for Child with Disabilities and Special Dietary Conditions
 - A Doctor's script pad is acceptable.
- **Provider:** Must keep copy in Child Care Food Program Binder. Submit a copy to the CCFP.

DEADLINE: Received in office within two (2) weeks of enrollment of a child with diet restrictions



Child Care Food Program Medical Statement for Children with Disabilities and Special Dietary Conditions

Child's Name: _____

Date: _____

Name and Address of Child Care Provider: _____

Dear Parent/Guardian and Recognized Medical Authority:

This child care provider participates in the Child Care Food Program (CCFP) and must serve meals and snacks meeting the CCFP requirements. Food substitutions must be made for children with a physical or mental disability when supported by a physician's statement. Food substitutions may also be made for children with special dietary conditions (unrelated to a disability) when supported by a statement signed by a physician, physician's assistant, nurse practitioner (ARNP), or registered dietitian. When supported by this documentation, the meal is not required to meet the meal pattern. Please return this completed form to the child care provider. If you have any questions, please contact me at _____.

Child Care Provider Phone Number

Sincerely: _____

Child Care Provider

A recognized medical authority must complete the following information.

1. Does the child identified above have a disability? A disability is defined as a physical or mental impairment which substantially limits one or more major life activities.

Yes

If yes:

a. State and describe the disability. _____

b. How does the disability restrict the diet? _____

c. What major life activity is affected? _____

No

If no:

Identify the medical condition (unrelated to a disability) that restricts the child's diet.

2. List any food(s) to be omitted from the child's diet.

3. List any food(s) to be substituted.

4. Describe any textural modification required.

Signature of Physician or Recognized Medical Authority
(For a disability, a physician must sign)

Printed Name

Date

Provider please mail to:

Coordinated Child Care of Pinellas, Inc.
6500 102nd Ave N
Pinellas Park, FL 33782