Child and Adult Care Food Program
MEDICAL EXCEPTION STATEMENT FOR FOOD SUBSTITUTION

CHILD’S NAME _______________________________ DATE _______________________________

NAME OF DAY CARE CENTER/HOME AND ADDRESS _______________________________

Dear Parent/Guardian:

This day care center/home participates in the Child and Adult Care Food Program (CACFP) and must serve meals and snacks meeting the CACFP requirements. Food substitutions may be made only when supported by a physician’s statement. Please ask your physician to complete and sign this form. Return the completed form to the day care center/home. If you have any questions, please contact me at:

__________________________________________________________

Day Care Center/Home Phone Number ______________________________

Day Care Center/Home Contact Person ______________________________

CACFP Sponsor – Keep Completed Form Signed by Physician on File at the Day Care Center/Home

Complete All Information

1. Does child have a disability according to 7 CFR Part 15b.3 (defined as “any person who has a physical or mental impairment which substantially limits one or more major life activities”)?

☐ Yes If yes, provide the following information and complete parts 3, 4 and 5.
☐ No If no, go to part 2.

   a. What is the disability? …………………  ___________________________________________

   b. How does the disability restrict the diet? __________________________________________

   c. What major life activity is affected? …..  __________________________________________

2. Child has no disability but requires a special diet. Provide the following information and complete parts 3, 4 and 5.

   Identify medical problem which restricts the child’s diet.

3. List food/type of food to be omitted.

4. List food/type of food to be substituted.

5. ______________________________  __________________________________________

   Date  Signature of Physician