**Child & Adult Care Food Program**

**Medical Statement to Request Special Meals and/or Accommodations**

The information on this form is CONFIDENTIAL and to be used for special dietary needs only.

1. Parent, Guardian, Authorized Representative completes this section; complete a separate medical statement for each child.

<table>
<thead>
<tr>
<th>Participant’s Name</th>
<th>Name of Care Provider/Facility</th>
<th>Facility Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent, Guardian, or Authorized Representative</td>
<td>Telephone of Parent/Guardian</td>
<td>Date</td>
</tr>
</tbody>
</table>

2. A Licensed Physician or Recognized Medical Authority check ONLY ONE box below. Please refer to regulatory definitions of disability and medical condition on reverse side of this form.

- [ ] Participant is disabled or has a food-related disability and requires a special meal or accommodation. Provider or facility must comply with prescribed special meals and any adaptive equipment.
- [ ] Participant is requesting a special meal accommodation due to allergies. Substitutions and/or accommodations may be made, but are not required.

3. Disability or medical condition requiring a special meal accommodation:

4. If the participant has a disability, provide a brief description of participant’s major life activity affected by the disability:

5. Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation)

6. Indicate Texture:
   - [ ] Regular
   - [ ] Chopped
   - [ ] Ground
   - [ ] Pureed

7. Please list specific foods to be omitted and suggested substitutions. Attach a sheet w/additional information if necessary.

<table>
<thead>
<tr>
<th>Food(s)/food types to be omitted</th>
<th>Suggested substitution(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Adaptive Equipment:

9. A Licensed Physician or Recognized Medical Authority signature is required on this form for a student who must not eat certain foods due to medical issues.

<table>
<thead>
<tr>
<th>Signature of Physician or Medical Authority</th>
<th>Printed Name &amp; Title</th>
<th>Telephone</th>
<th>Date</th>
</tr>
</thead>
</table>

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