

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	d. Vitamin D 100 IU	g. Potassium 349 mg
b. Protein 8 g	e. Magnesium 24 mg	h. Riboflavin .44 mg
c. Vitamin A 500 IU	f. Phosphorus 222 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*