Oregon Department of Education
Public Service Building
255 Capitol St NE
Salem, OR 97310

Child Nutrition Programs
(503) 947-5902

Child and Adult Care Food Program (CACFP)

MEDICAL STATEMENT FOR FOOD SUBSTITUTIONS

Part I: To be completed by parent, guardian, or adult day care participant, as applicable.

Date: _____ Participant's Name: _____

Parent or Guardian's Name (if applicable): _____

Day Care Provider / Facility: _____

Part II: to be completed by a *Recognized Medical Authority*

Recognized Medial Authorities: physician (MD), physician's assistant (PA), nurse practitioner (NP), registered nurse (RN), or a registered dietitian (RD).

Date: _____ Participant's Name: _____

Medical Condition that requires participant to have food substitutions: _____

_____

_____

Food(s) to be omitted from diet:	Foods to be substituted:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I certify the above named patient/client requires the food substitutions described above for medical reasons:

Signature of Medical Authority _____