



Nutrition Works

1607 W. Jefferson • Boise, ID 83702

MEDICAL STATEMENT FOR FOOD SUBSTITUTIONS
Child and Adult Care Food Program (CACFP)

Part I: To be completed by parent or guardian (as applicable)

Date: _____ Child's Name: _____

Parent or Guardian's Name: _____

Child Care Provider/Facility: _____

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

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

Date: _____ Patient /Client's Name: _____

Medical condition that requires participant to have food substitutions: _____

Food(s) to be omitted from diet:

Food(s) to be substituted:

| Food(s) to be omitted from diet: | Food(s) to be substituted: |
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I certify the above named patient/client requires the food substitutions described above for medical reasons.

Signature of Medical Authority _____