MEDICAL STATEMENT FOR CHILDREN WITHOUT DISABILITIES
in the Child and Adult Care Food Program (CACFP)

This medical statement is for nondisabled children who require special dietary accommodations to CACFP meals. **This form must be completed in its entirety and submitted to the CACFP child care center or family day care home before the CACFP facility can make any meal substitutions for nondisabled children.** The parent/guardian should review this form annually and initial and date if no changes are needed. Any changes require the submission of a new form signed by the child's recognized medical authority.

PART 1 – TO BE COMPLETED BY PARENT/GUARDIAN. *PLEASE PRINT.*

Child's Name: ______________________ Birth Date: ____/____/____ *(month/day/year)* ☐ Male ☐ Female

Parent/Guardian's Name: ______________________

Work Phone: ( ) – ______ Home Phone: ( ) – ______

Address: ______________________ City: __________ State: ____ Zip: ______

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA) I hereby authorize

____
(Name of Recognized Medical Authority)

to release such protected health information of my child as is necessary for the specific purpose of special diet information to

____
(Name of CACFP Child Care Center or Family Day Care Home)

and I consent to allow the recognized medical authority listed above to freely exchange the information listed on this form and in my child's records with the child care program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that I may rescind permission to release this information at any time except when the information has already been released. My permission to release this information will expire on

____
(Expiration Date) *

* ***Note:*** *The recommended expiration date is for a period of one year so that updates to the medical statement can be made in conjunction with the child's annual physical.*

Parent/Guardian Signature: ______________________ Date: __________

PART 2 – TO BE COMPLETED BY A RECOGNIZED MEDICAL AUTHORITY. *PLEASE PRINT.*

The Connecticut State Department of Public Health defines a ***recognized medical authority*** *as a physician, physician assistant, doctor of osteopathy or advanced practice registered nurse (APRN). APRNs include nurse practitioners, clinical nurse specialists and certified nurse anesthetists who are licensed as APRNs.*

A. Describe the medical or other special dietary need that restricts the child's diet:

B. List foods to be **omitted** from the diet and foods to be **substituted** (attach specific diet plan):
Note: A specific diet plan ***must*** *be provided before the CACFP child care center or family day care home can make any meal substitutions for the child.*

C. List foods that require a change in texture. If all foods need to be prepared in this manner, indicate "All."

- ☐ Cut up or chopped to bite-size pieces *(List foods):*
- ☐ Finely ground *(List foods):*
- ☐ Pureed *(List foods):*

D. List any special equipment or utensils needed:

E. Indicate any other comments about the child's eating or feeding patterns:

Name of Recognized Medical Authority: ______________________ Office Phone Number: ( ) –

Signature of Recognized Medical Authority: ______________________ Date: ____________

Office Stamp:

This form is available as a PDF document at www.sde.ct.gov/sde/lib/sde/pdf/deps/nutrition/cacfp/sdn/medical_cacfp.pdf and a Word document at www.sde.ct.gov/sde/lib/sde/word_docs/deps/nutrition/cacfp/sdn/medical_cacfp.doc.

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