Medical Statement for CACFP Participants Requiring Meal Modifications

1. Name of Participant:	2. Birth date:
3. Name of Parent/Guardian (if participant is a child):	4. Daytime Phone:

5. Disability or Medical Condition requiring modification of meals:	6. Major life activity affected by the disability *(please circle all that apply)*: caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working

Required Meal Modification ***(check all which apply):***

7. _____RESTRICTED NUTRIENT	8. _____INCREASED NUTRIENT	9. _____MODIFIED TEXTURE
_____ Calorie _____ Controlled Carbohydrate _____ Protein _____ Sodium _____ Fat/Cholesterol	_____ Calorie _____Protein _____Fiber _____Other:	Describe required modification:

7 – 9. Additional information:
10. _____FOODS TO BE OMITTED FROM THE DIET

10 a. List all that apply	10 b. Foods that may be substituted

11. Special Utensils Needed:
12. Tube Feeding Required:
13. Other Accommodations needed:

14. For participant with a disability:	Signature of Physician: Date:
15. For non-disabled participant:	Signature of Other Medical Authority: Date:

Instructions are on the reverse side.

Instructions

1. Name of CACFP Participant who needs the modified meal.

2. Birth date of participant.

3. Name of Parent or guardian if the participant is a child, leave blank if the participant is an adult.

4. Telephone number where parent or guardian can be reached during the day in case of questions about the medical statement. Leave blank if the participant is an adult.

5. Briefly state or describe the medical condition or disability that necessitates the meal modification.

6. If the condition is a disability, indicate which life functions the disability affects by circling the appropriate item(s). If another life activity is more appropriate, write it in. If the medical condition is not a disability leave this section blank.

7. If the needed modification is a restriction of a specific nutrient, indicate by checking the appropriate line. Addition information about this requirement may be written in section below.

8. If the needed modification is to increase specific nutrients, check the appropriate line. Addition information about this requirement may be written in section below.

9. If the needed modification is to modify the texture of the meal, briefly describe in the space provided. Addition information about this requirement may be written in section below.

10. If certain foods should be eliminated from the diet this line should be checked. Write in the box for 10 a. the foods that must not be served to this participant. Foods that should be substituted should be written in box 10b. For example if the person is allergic to nuts, they would be listed in box 10 a. There may not need to be a substitute. But if the child is allergic to milk and the physician wants calcium-added soy milk substituted, it would be written in box 10b.

11. Special utensils that allow the person to feed himself or herself might include modified plates or eating utensils, cups with tops, etc.

12. If tube feeding is required write in this box who would be responsible, the times it would administered, etc.

13. Any other accommodations needed or further information can be written in this box.

14. If this accommodation is for a person with a disability, and therefore the Program is required to make the accommodation, the form must be signed by a physician.

15. If this accommodation is for a medical condition that is not a disability, and therefore the Program is encouraged but not required to make the accommodation, it can be signed by a recognized medical authority such as a nurse or dietitian.