Child Care Food Program
Medical Statement for Children with Disabilities and Special Dietary Conditions

Child's Name: _____ Date: _____

Name and Address of Child Care Center: **Smart Horizons Learning Center - 1590 NE 8TH ST Homestead FL 33033**

_____

Dear Parent/Guardian and Recognized Medical Authority:

This child care center participates in the Child Care Food Program (CCFP) and must serve meals and snacks meeting the CCFP requirements. Food substitutions must be made for children with a physical or mental disability when supported by a statement signed by a physician, physician's assistant (PA), nurse practitioner (ARNP). Food substitutions may also be made for children with special dietary conditions (unrelated to a disability) when supported by a statement signed by a physician, physician's assistant (PA), nurse practitioner (ARNP), or registered dietitian. When supported by this documentation, the meal is not required to meet the meal pattern. Please return this completed form to the child care center. If you have any questions, please contact me at **(786) 339-8025**.

Child Care Center Phone Number

Sincerely: **Ms. Cruz**

Child Care Center Director

A recognized medical authority must complete the following information.

1. Does the child identified above have a disability? A disability is defined as a physical or mental impairment which substantially limits one or more major life activities.

   ☐ Yes **If yes:**
   a. State and describe the disability. _____
   b. How does the disability restrict the diet? _____
   _____
   c. What major life activity is affected? _____

   ☐ No **If no:**
   Identify the medical condition (unrelated to a disability) that restricts the child's diet.
   _____

2. List any food(s) to be omitted from the child's diet.
   _____

3. List any food(s) to be substituted.
   _____

4. Describe any textural modification or adaptive equipment required.
   _____

_____ _____
Signature of Physician or Recognized Medical Authority (For a disability – a physician, PA, or ARNP must sign) Date

_____ _____
Printed Name Phone Number