MEDICAL STATEMENT FOR PARTICIPANTS WITH DISABILITIES OR MEDICAL CONDITIONS

This section is to be completed by a Parent, Guardian, or Authorized Representative		
Participant's Name:		**Birthday:**
Parent/Guardian/Authorized Representative name:		
Home Phone: ( )		**Work Phone: ( )**
Address:		
City:	**State:**	**Zip:**

This section is to be completed by a State licensed healthcare professional such as a physician or nurse practitioner.	
Brief explanation of how exposure to the food affects the participant:	
Foods to be omitted:	**Recommended Alternatives:**
Please list foods and information regarding any needed texture changes (chopped, ground, pureed, etc.):	
Please provide any other information regarding the diet:	

Recognized Medical Authority: Anyone who can prescribe medication.

Physician/Nurse Practitioner's Signature **Date**

Printed Name and Title **Telephone**

**7 CFR 226.20 (h) & Policy Memo: CACFP 14-2017*