

**MEDICAL STATEMENT FOR CHILD WITH ALLERGIES/
CHRONIC DISEASES/DISABILITIES REQUIRING SPECIAL MEALS – CACFP/SFSP**

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
CHILD NUTRITION AND FOOD DISTRIBUTION PROGRAMS
Rev. 6/03) G/Tools/CACFP/Medical Statement for Child with Allergies-CACFP/SFSP

Name of Child:	Center Site:
DOB:	Center Attended:
Parent Name:	Telephone:
Telephone:	
Diagnosis (i.e., food allergy or chronic disease or disability)	
If a disability, describe the major life activity affected by the disability	
Diet Prescription and/or Texture and Liquids Modification (Describe in detail to ensure proper implementation and compliance.)	
Indicate texture: <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed	
Indicate thickness of liquids: <input type="checkbox"/> Regular <input type="checkbox"/> Nectar <input type="checkbox"/> Honey <input type="checkbox"/> Pudding	
<i>List foods to be omitted from the diet and foods that may be substituted (may use the back of this form)</i>	
Omitted Food	Suggested Substitution
Omitted Food	Suggested Substitution
Omitted Food	Suggested Substitution
Special Feeding Equipment	
Signature of Physician	Printed Name
Telephone	Date
Signature of Preparer or Other Contact	Printed Name
Telephone	Date