Medical Statement for Meal Modifications in Child and Adult Care Food Program (CACFP) Child Care Programs

This form applies to requests for meal modifications for children participating in the U.S. Department of Agriculture's (USDA) CACFP child care facilities, which include child care centers, at-risk afterschool care centers, emergency shelters, and family day care homes. CACFP facilities are required to make reasonable meal modifications for children whose physical or mental impairment restricts their diet. For guidance on meal modifications and instructions for completing this form, see the Connecticut State Department of Education's (CSDE) document, *Guidance and Instructions for the Medical Statement for Meal Modifications in CACFP Child Care Programs*.

Note: The USDA requires that the medical statement includes: 1) information about the child's physical or mental impairment that is sufficient to allow the CACFP facility to understand how the impairment restricts the child's diet; 2) an explanation of what must be done to accommodate the child's disability; and 3) if appropriate, the food or foods to be omitted and recommended alternatives. **CACFP facilities should not deny or delay a requested meal modification because the medical statement does not provide sufficient information.** When necessary, CACFP facilities should work with the child's parent or guardian to obtain the required information. While obtaining additional information, the CACFP facility should follow the portion of the medical statement that is clear and unambiguous to the greatest extent possible.

Section A – Completed by parent or guardian

1. Name of child: _____ 2. Birth date: _____
3. Name of parent or guardian: _____
4. Phone number (with area code): _____ 5. Email address: _____
6. Address: _____ City: _____ State: _____ Zip: _____

7. 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 child's recognized medical authority
to release such protected health information of my child as is necessary for the specific purpose of special diet information to _____ and I consent to allow the recognized medical authority to freely
name of CACFP child care center or family day care home
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.

8. Signature of parent or guardian: _____ 9. Date: _____

Section B – Completed by child's recognized medical authority

This section must be completed by the child's 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.

10. **Physical or mental impairment:** Does the child have a physical or mental impairment that restricts the child's diet?
☐ **No** ☐ **Yes:** Describe how the child's physical or mental impairment restricts the child's diet.

11. **Diet plan:** Explain the meal modification for the child. Attach a specific diet plan, if needed.

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Section B – Completed by child's recognized medical authority, continued

13. **Food omissions and substitutions:** List foods to be omitted from the child's diet and foods to be substituted.

14. **Food texture:** List foods that require a change in texture. Indicate "all" if all foods should be prepared in this manner.
    - ☐ Cut up or chopped into bite-size pieces: _____
    - ☐ Finely ground: _____
    - ☐ Pureed: _____

15. **Equipment:** List any special equipment or utensils needed.

16. **Additional information:** Indicate any other information about the child's eating or feeding patterns that will assist in providing the requested meal modification.

17. Name of recognized medical authority: _____ 18. Phone number (with area code): _____

19. Signature of recognized medical authority: _____ 20. Date: _____

21. Office stamp:

This form is available at https://portal.ct.gov/-/media/SDE/Nutrition/CACFP/SpecDiet/Medical_Statement_CACFP.pdf