Medical Statement for Children *with* Disabilities

Requiring Special Meals in the Child and Adult Care Food Program (CACFP)

This statement must be completed in its entirety and submitted to the CACFP facility before any meal substitutions can be made for children with disabilities. The parent/guardian should review this form annually and initial and date if no changes are needed. Any changes require the submission of a new form signed by the child's physician.

PART 1 – TO BE COMPLETED BY PARENT/GUARDIAN. *PLEASE PRINT.*

Child's Name: ______________________ Birth Date: ____/____/____ ☐ Male ☐ Female
(month/day/year)

Parent/Guardian's Name: ______________________

Work Phone: (   )   – ________ Home Phone: (   )   – ________

Address: ______________________ City: __________ State: _____ Zip: ________

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 Physician)

to release such protected health information of my child as is necessary for the specific purpose of special diet information to

____
(Name of CACFP Center or Home)

and I consent to allow the physician to freely 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. My permission to release this information will expire on

____
(Expiration Date*)

* **Note:** The recommended expiration date is for a period of one year so that updates to the medical statement can be made in conjunction with the child's annual physical.

Parent/Guardian Signature: ______________________ Date: ____________

PART 2 – TO BE COMPLETED BY LICENSED PHYSICIAN. *PLEASE PRINT.*

The Connecticut State Department of Public Health defines a licensed physician as a doctor of medicine or osteopathy.

A. Describe the patient's disability and the major life activity affected by the disability:

B. Does the disability restrict the individual's diet? ☐ Yes ☐ No
If yes, the physician must complete C through F on the next page, sign and stamp the form with the office name and address.

Medical Statement for Children *with* Disabilities, continued

C. List foods to be **omitted** from the diet and foods to be **substituted** (attach specific diet plan):
*Note: A specific diet plan **must** be provided before the CACFP center/home can make any meal substitutions for the child.*

D. List foods that require a change in texture. If all foods need to be prepared in this manner, indicate "All."

Cut up or chopped to bite-size pieces:

Finely ground:

Pureed:

E. List any special equipment or utensils needed:

F. Indicate any other comments about the child's eating or feeding patterns:

Physician's Name: ______________________________ Office Phone Number: (   )   –

Physician's Signature: ______________________________ Date: ______________

Office Stamp:

In accordance with federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free 866-632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339 or 800-845-6136 (Spanish). USDA is an equal opportunity provider and employer.