IDAHO
STATE DEPARTMENT OF EDUCATION

Child and Adult Care Food Program
Medical Statement for Food Substitutions

Name of Facility: **College of Southern Idaho Head Start/ Early Head Start**

Child's Name: *Nombre del Niño*: ____________________
Parent's Name: *Nombre de padres*____________________
Parent's Phone Number: *Numero de Teléfono:*____________________

Medical condition that requires child to have food substitution(s): *Condición medica por la cual se require la sustitución:*____________________

EHS/ Head Start Center & classroom : *Nombre del Centro de Head Start y salón :*____________________
Substitution Effective through: *Substitución Efectiva Hasta:*____________________

Food(s) to be Omitted from diet: *Comida(s) que se debén omitir:*	**Recommended Food Substitution(s):** *Comida(s) que se pueden sustituir:*
____________________	____________________
____________________	____________________
____________________	____________________

I certify that the above named child requires the food substitution(s) as described for medical reasons:
____
____

____________________ ____________________
Recognized Medical Authority Signature **Date**

* A recognized medical authority is a physician, physician's assistant, nurse or a registered dietitian.

Printed Name and Title:____________________

Address:____________________

____________________ ____________________
Parent(s) Signature / ***Firma del Padre/ Guardián*** **Date/** ***Fecha***

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