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 deben 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

“In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age or disability.”