Medical Statement for Participants with Unique Mealtime Needs

When completed fully, this form gives Centers the information required by the U.S. Department of Agriculture (USDA), and U.S. Office for Civil Rights (OCR) for meal modifications in any Child Nutrition Program.

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| PART A *(To be completed by PARENT/GUARDIAN/PARTICIPANT)* | | | | | | | | | | | | | |
| PARTICIPANT INFORMATION | | Last Name: | | First Name: | | | Middle Name: | | | | | Date of Birth | |
| Center | | | | | | Age | |  | | | |
| USDA PROGRAM | | 🞏 Child and Adult Child Care Program (CACFP) | | | | | | | | | | | |
| PARENT/GUARDIAN/  PARTICIPANT  CONTACT INFORMATION | | Printed Name of PARENT/GUARDIAN: | | | | | | | | | | | |
| Mailing Address: | | | City: | | | | | | State: | | Zip Code: |
| Work Phone: | Island | | Cell Phone: | | | | Email: | | | | |
| Please describe the concerns you have about the individual’s nutritional needs: | |  | | | | | | | | | | | |
| Please describe the concerns you have about the individual’s ability to safely participate: | |  | | | | | | | | | | | |
| Does the participant have an Individualized Education Program (IEP)?  🞏 YES 🞏 NO 🞏 N/A | | | | | | *NOTE: Unique mealtime needs for participants without an IEP, 504 or disability, but with general health concerns, are addressed within the meal pattern at the discretion of the CACFP organization.* | | | | | | | |
| Does the participant have a 504 Plan?  🞏 YES 🞏 NO 🞏 N/A | | | | | |
| **PARENT/GUARDIAN/ PARTICIPANT Consent** | *I agree to allow the participant’s health care provider and center personnel to communicate as needed regarding the information on this form.*  **Parent/Guardian/Participant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
|  | Please return this fully completed Medical Statement with signatures from both parent/guardian/participant and medical authority, to the center or family day care home. | | | | | | | | | | | | |

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| PARTICIPANT NAME: |  | | | | | | | | Date of Birth: | | |  | | |
| PART B *(To be completed by a RECOGNIZED MEDICAL AUTHORITY* | | | | | | | | | | | | | | | |
| Describe the participant’s physical or mental impairment: | | | | | | | Explain how the impairment restricts the participant’s diet: | | | | | | | | |
| Major life activities affected:  *Select all that apply.* | | 🞏 Walking 🞏 Seeing 🞏 Hearing 🞏 Speaking  🞏 Performing manual tasks 🞏 Learning 🞏 Breathing  🞏 Self-Care 🞏 Eating/Digestion | | | | | | | | 🞏 Adaptive Equipment *(please specify):* | | | | | |
| Is this a Food Allergy? 🞏 YES 🞏 NO  Is this a Food Intolerance? 🞏 YES 🞏 NO | | | | | | If participant has life threatening allergies\* check appropriate box(es):  *\*Participants with life threatening food allergies must have an emergency action plan in place at the center.* 🞏 Ingestion 🞏 Contact 🞏 Inhalation | | | | | | | | | |
| Specify any dietary restrictions or special diet instructions for accommodating the participant in center meals: | | | | | | | | | | | | | | | |
| For *any* special diet, list specific foods to be omitted and the recommended substitutions.  *(You may attach a separate care plan)* | Foods to be Omitted | | 🡺 | | Recommended Substitutions | | | Foods to be Omitted | | | 🡺 | | | Recommended Substitutions | |
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| Designate safest consistency requirement for FOOD: | | Designate safest consistency requirement for LIQUIDS: | | |
| 🞏 Pureed 🞏 Mechanical Soft  🞏 Ground 🞏 Chopped | 🞏 Other *(please specify):* | 🞏 Clear Liquid  🞏 Nectar thick 🞏 Full Liquid 🞏 Honey-thick  🞏 Pudding-thick | | 🞏 Other *(please specify):* |
| Other comments about the individual’s eating or feeding patterns, including tube feeding if applicable: | | | *\*NOTE\* If your assessment of the participant does not yield sufficient data to fully complete the above sections applicable to the participant’s mealtime needs, please refer the family to the appropriate health care professional for completion of the assessment.* | |

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| Signature of Recognized Medical Authority\* | Printed Name | Phone Number | Date |
| A recognized medical authority in Hawai’i includes licensed physicians, physician assistants, registered dietitian, naturopathic physician, nurse practitioners, or osteopathic physician. | | | |

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| PART C (*To be completed by CACFP ADMINISTRATORS)* | NOTES:  *CACFP Administrator* |
| Organization Administrator’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Health, IEP/504 Coordinator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please return this fully completed Medical Statement with signatures from both parent/guardian/participant and medical authority, to the center or family day care home. | Received on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Processed date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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1. Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;
2. Fax: (202) 690-7442; or
3. Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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