



Medical Statement

A state licensed healthcare professional who is authorized to write medical prescriptions under state law or registered dietitian must complete Parts 2 and 3 and sign this form. In the Florida CCFP, a licensed medical professional is a Physician, Physician's Assistant and Nurse Practitioner (ARNP). A Registered Dietitian (RD) may also complete and sign the form. The parent or guardian must complete Part 1.

PART 1: GENERAL INFORMATION - Completed by the parent/guardian

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|---------------------|---------------|
| First and Last Name | Date of Birth |
|---------------------|---------------|

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|------------------------------|--|
| Name of Center/Care Provider | |
|------------------------------|--|

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|-------------------------|------------------|
| Name of Parent/Guardian | Telephone Number |
|-------------------------|------------------|

PART 2: ACCOMODATIONS - Completed by a licensed medical professional

How does the participant's physical or mental impairment restrict their diet?

What food(s)/type(s) of food must be omitted? Please be specific.

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|---|---|
| If a "Cow's Milk"/Dairy allergy, can the child eat the following: | If Eggs/Whole Eggs are listed as an allergy but stated can be "cooked in", can the child eat the following: |
| 1. Milk/Dairy products in baked goods? Y or N | 1. Baked breads with egg ingredient? Y or N |
| 2. Milk/Dairy products like Mac & Cheese/Alfredo sauce? Y or N | 2. French toast? Y or N |
| 3. Yogurt? Y or N | 3. Foods with mayonnaise as an ingredient? Y or N |
| 4. Cheese? Y or N | |

List food(s) to be substituted for omitted food(s). (Avoid specific brand names, if possible)

Additional comments:

Texture modification (Complete if needed):

| | | | |
|---------------------------------|---------------------------------|---|--|
| <input type="checkbox"/> Pureed | <input type="checkbox"/> Ground | <input type="checkbox"/> Bite-Size Pieces | <input type="checkbox"/> Other (specify) |
|---------------------------------|---------------------------------|---|--|

PART 3: SIGNATURE - Completed by a licensed medical professional or registered dietitian

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| Licensed medical professional's name | Title: <input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner (ARNP) <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Registered Dietitian (RD) |
| Signature of licensed medical professional or registered dietitian | Date signed |
| Medical office name and address | Phone number |