Plan of Care- Medical Dietary Needs

This form is to be used to document medical dietary needs requiring meal or snack modifications for a child participating in the Child and Adult Care Food Program (CACFP). Completion of this form by a licensed medical provider is ***required*** for medical dietary accommodations.

Student Information:

Student Name	
Date of Birth	
Age	
Program Site / Location	
Date Plan Completed	
Review Date	

Parent/Guardian information:

Parent/Guardian Name	
Phone Number	
Email Address	

Medical Dietary Need (to be completed by licensed medical provider):

Medical condition or disability impacting diet:	
Foods to be omitted or restricted:	
Required substitutions or modifications (please be very specific):	

CACFP Compliance Statement:

Medical dietary accommodations supported by this form must be implemented as written. When required substitutions do not meet standard CACFP meal patterns, meals may still be claimed for reimbursement when supported by a valid medical statement.

Accommodation Duration:

Effective Date	
End Date (if applicable)	

Medical Provider Certification:

Medical Provider Name:	
Provider Credentials:	
Provider Phone Number:	
Provider Signature and Date:	

Parent/Guardian Acknowledgement:

I understand that this medical dietary accommodation will be implemented as written and that updated documentation may be required if the condition or needs change.

Parent / Guardian Name	
Signature	
Date	