Special Dietary Needs

Medical Statement

Florida Department of Health
Child Care Food Program
FloridaHealth.gov/CCFP
850-245-4323 • CCFP@FLhealth.gov

A licensed healthcare professional who is authorized to write medical prescriptions under state law (physician, physician's assistant, nurse practitioner) or registered dietitian must complete parts 2 and 3 of this form. The child's parent or guardian must complete part 1.

PART 1: GENERAL INFORMATION - Completed by Parent/Guardian

Child's First and Last Name: _____ **Date of Birth:** _____

Name of Center/Care Provider: _____

Name of Parent or Guardian: _____ **Phone Number:** _____

PART 2: ACCOMODATIONS - Completed by Licensed Healthcare Professional or Registered Dietitian

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

_____

_____

What food(s)/type of food(s) must be omitted from the diet? Please be specific:

_____

_____

List food(s)/type of food(s) to be substituted: Please be specific:

_____

_____

Texture Modification (if needed): Check box to the left of modification required

☐ Pureed ☐ Ground ☐ Bite-sized Pieces ☐ Other, please specify: _____

Please check if applicable:

Dairy/Lactose

☐Lactose Intolerant ☐Dairy Allergy

Can child consume the following:

Milk/dairy products in baked goods: ☐Yes ☐ No

Milk/dairy products in entrée items: ☐Yes ☐ No

Yogurt: ☐Yes ☐ No

Cheese: ☐Yes ☐ No

Eggs

If eggs or whole eggs are listed as an allergy for the child, but stated can be cooked in or prepared with,
Can the child consume the following:

Breads containing eggs: ☐ Yes ☐ No

French toast, pancakes, muffins: ☐ Yes ☐ No

Foods containing mayonnaise: ☐ Yes ☐ No

PART 3: SIGNATURE - Completed by Licensed Healthcare Professional or Registered Dietitian

Name of Healthcare Provider: _____ **Phone Number:** _____

Facility/Office Name: _____

Facility/Office Address: _____

Signature: _____ **Date:** _____