Medical Referral Form for Modified Meals

The center must secure this information for participants who require modified diets.

Date_______________

Participants's Name______________________Birth Date_____________________

Food Allergies/Intolerances: ____

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Special diet/dietary restrictions/modified meals requested:

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<u>Note to Physician</u>:

The center has been requested to serve this participant modified meals in the Child And Adult Care Food Program (CACFP). To ensure, that in so doing, the participant's medical requirements are being met appropriately, we request that you complete this form.

Are there foods that <u>should not be</u> served to this participant?

_______Yes _______No

If yes, list foods that should not be served:

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If yes, also list suggestions for alternative foods that may be served to this participant:

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Additional Recommendations and/or Requirements:

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Signature of Physician________________________________Date____________________

Office Address ___________________________________Phone __________________