GRACE
Early Learning Center

Medical Statement for Participants with Disabilities or Medical Conditions

This Section To Be Completed By A Parent, Guardian, Or Authorized Representative

Participant's Name: | Birthday:

Parent/Guardian/Authorized Representative's Name:

Home Phone: | Work Phone

Address:

City: | State: | Zip

This Section To Be Completed By A State Licensed Healthcare Professional, Such As A Physician Or Nurse Practitioner*

Description of the participant's physical or mental impairment:

Foods to be omitted: | Recommended Alternatives:

Please list the foods and information regarding any needed texture changes (chopped, ground, pureed, etc.):

Please provide any other information regarding the diet:

**Recognized Medical Authority: Anyone who can prescribe medication.*

Physician/Nurse Practitioner's Signature: | Date:

Printed Name & Title: | Telephone:

**7 CFR 226.20 (g) & Policy Memo: CACFP 14-2017*