COLORADO
Department of Public Health & Environment

Child and Adult Care Food Program
Special Diet Statement
(Food preferences are not an appropriate use of this form)

Instructions to complete the form:
Please carefully read and follow the instructions provided to request a special meal or accommodation to the CACFP meal pattern. The Special diet statement form should only be completed for participants who have a physical or mental impairment that limits one or more major life activities (includes eating, breathing, digestive and respiratory functions, etc.) and requires a special meal or accommodation.

Institutions and facilities participating in the Child and Adult Care Food Program (CACFP), **must** comply with the request specified in the special diet statement at no extra charge for the participants with documented disabilities and/or a medical need

1. Name of Participant (Last, First)	**2. Age or Date of Birth**
3. Name of Parent or Guardian	**4. Telephone Number**
5. Institution/Child Care Provider Name	**6. Telephone Number**

Medical Authority Only. Sections 7-11 should be completed by the Medical Authority.

7. Describe the impairment(s) or reason(s) for request (brief explanation of how exposure to food(s) affects participant):

8. Foods to be omitted and substitutions:
List specific foods to be omitted and suggested substitutions. Attach an additional sheet with more information if needed. Example: Foods to be Omitted: "Fluid milk and soy milk or soy products." Suggested Substitutions: "Serve almond milk instead."

A. Foods To Be Omitted	B. Suggested Substitutions

9. If texture accommodations are needed, indicate texture needed by checking one of the boxes below:
Chopped ☐ Ground ☐ Pureed ☐ Liquid ☐ Other: ☐ Specify: _____

10. Adaptive Equipment
If the participant needs a special equipment, describe the specific equipment required to assist the participant with dining. Examples may include a sippy cup, a large handled spoon, wheel chair accessible furniture, etc.

11. Licensed Physician (MD, DO), Advance Practice Nurse, Dentist, or Physician Assistant information*

Signature	**Title**	
Printed name	**Telephone**	**Date**
Medical Office Name and Address		
Parent/Legal Guardian Signature	**Date**	

***** A completed Special Diet Statement form must be signed by a Licensed Physician (MD or DO), Advanced Practice Nurse (APN) with prescriptive authority (RXN), Dentist (DDS DMD) or Physician Assistant (PA).

This form must be updated annually. If the participant is an infant, this form must be updated every six months.

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