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Nutrition Service
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MEDICAL STATEMENT FOR FOOD SUBSTITUTIONS

Child's Name _____

Parent's Name _____

Name of Child Care Provider _____

Medical Condition That Requires Child To Have Food Substitution (s)

Food to be Omitted

Recommended Food Substitution

_____	_____
_____	_____
_____	_____

I certify that the above named child requires the food substitution (s) as described for medical reasons:

Print Name and Title

*Recognized Medical Authority Signature

Date _____

* A recognized medical authority is a physician, physician's assistant, nurse or registered dietitian.

“USDA and the State of Oregon are equal opportunity providers and employers.”