Child Care & Nutrition, Inc. • PO Box 138 • Ivanhoe, MN 56142
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Infant Formula /Special Diet /Disability Statement

Name of Provider:________________________________ Provider ID Number_______________

Instructions: Please fill out the appropriate section for the needs of the child(ren) in care.

Infant Formula Statement (6 weeks to one year)

Important! Infants MUST be offered at least one type of formula by the PROVIDER! If, as a parent, you do ***NOT*** wish to use that brand or type of Iron-Fortified Infant Formula (IFIF), you have the option of supplying your own and the provider can still claim meals for reimbursement for your infant. ***If parents choose to supply IFIF, then please fill out the information below so we know arrangements made is the parent's choosing.***

Child's Name:______________________________________ Date of Birth_____________________

____________________________Brand/Type of IFIF (Iron Fortified Infant Formula) Provider Supplies

_____ "I do not wish to have my child using above named brand".

____________________________________IFIF Parent Supplied brand/type (MUST be Iron Fortified)

Parent's Signature: Date:

Special Diet Statement (6 weeks through 12 years)

If your child cannot eat foods required by the CACAP guidelines, a diet statement from a recognized medical authority* is necessary. Please have the medical authority fill out the statement below and give to your family child care provider. Your child may then participate in the CACFP and still follow the diet prescribed.

Child's Name ____Date of Birth_____________
List the food item omitted and the appropriate substitutes

Omit:____

Substitute:____

*Clinic Name*_________________________**Signature*_________________________*Date*____________

***Recognized medical authority includes**: Doctor, Certified Nurse Practitioner, Physician's Assistant, Chiropractor, Registered Dietitian, or Licensed Nutritionist.

Disability Statement (all ages)

If this facility cares for the majority of children under age 18, a person of any age with physical or mental disabilities (unable to care for themselves independently) may be claimed on the CACFP.

Person's Name:____ Date of Birth____________

Type of Disability:____

*Clinic Name*____

Licensed Physician Signature *Date*

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Original: CCNI **Pink Copy: Provider** **Yellow Copy: Parent**