Iowa Child and Adult Care Food Program
ALLERGY/FOOD EXCEPTION STATEMENT

Description: The Child and Adult Care Food Program (CACFP) is funded by the United States Department of Agriculture (USDA). The CACFP reimburses home providers for children's meals that meet USDA requirements. If an infant or child needs to avoid specific foods for a medical reason, reimbursement is allowed only if a recognized medical authority has documented the need for an exception.

Please complete this form and return to: ________________________________ (Name of child development home)

Child's/Infant's Name: ________________________________ Birth Date: ________________________________

Parent's/Guardian's Name: ________________________________

Signature of Parent: ________________________________ Date: ________________________________

(For permission to release information to the Home Sponsor)

1) Disability: Does the infant/child have a disability? O Yes O No If yes, a physician must sign this form. If the child is not disabled the form may be signed by any of the health care practitioners listed below.

If yes, describe the major life activities affected by the disability:

2) Special Dietary/Feeding Needs: Does the infant/child have a food allergy or intolerance? O Yes O No

If yes, describe the nature of the allergy/intolerance:

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<th>Food(s) or Formula to Avoid:</th>
<th>Food(s) or Formula to Substitute:</th>
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<td>Infants at CACFP homes must receive iron-fortified infant formula or breast milk unless an allergy/exception statement is on file.</td>
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Other dietary or feeding needs for the infant/child:

Date for a recheck or re-evaluation: ________________________________

Health Care Practitioner: ________________________________ Name (Print or Type) ________________________________ Title ________________________________

[Health care practitioner must be one of the following: medical doctor (MD), doctor of osteopathic medicine (DO), physician’s assistant (PA) or advanced registered nurse practitioner (ARNP)].

Address: ________________________________

Signature of Health Care Practitioner ________________________________ Date ________________________________