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SUMMER FOOD SERVICE PROGRAM
MEDICAL EXCEPTION STATEMENT FOR FOOD SUBSTITUTION

CHILD'S NAME	DATE

NAME OF SFSP SITE AND ADDRESS

Dear Parent/Guardian:

This site participates in the Summer Food Service program (SFSP) and must serve meals and snacks meeting SFSP requirements. Food substitutions may be made only when supported by a physician's statement. Please ask your physician to complete and sign this form. Return the completed form to the SFSP site. If you have any questions, please contact me at

_____.
SFSP Sponsor Telephone Number

Sincerely,

_____
SFSP Contact Person

SFSP Sponsor–keep completed form signed by physician on file at the SFSP site.

COMPLETE ALL INFORMATION

1. Does child have a disability according to 7 CFR Part 15b.3 *(*defined as *any person who has a physical or mental impairment which substantially limits one or more major life activities)*?

   ☐ **YES** **If yes, provide the following information and complete parts 3, 4, and 5.**

   ☐ **NO** **If no, go to part 2.**

   a. What is the disability? _____

   b. How does the disability restrict the diet? _____

   c. What major life activity is affected? _____

2. Child has no disability but requires a special diet.
   Provide the following information and complete parts 3, 4, and 5.
   Identify medical problem which restricts the child's diet.

3. List food/type of food to be omitted.

4. List food/type of food to be substituted.

5._____ _____
Date *Signature of Physician*

Print Reset Form