

PARENT'S/GUARDIAN'S FORM FOR DECLINING A PROVIDER'S FORMULA

All child care facilities (providers or centers) participating in a Child Nutrition Program (CNP) are required to offer at least one infant formula which meets the definition of infant formula according to State and Federal guidelines, unless breast milk is being provided by the infant's mother. The provider or center has selected a formula that complies with the Federal guidelines.

As a parent or guardian, you have chosen to decline the provider's or center's offered formula and will furnish a formula that meets the CNP requirements for iron fortification and nutritional content, unless your doctor has prescribed a special formula. If your doctor's prescribed formula does not meet the CFP requirements, you will need to have him/her complete a medical statement. Return the original to your provider. Please complete the form below in order to allow your provider or center to receive CNP meal reimbursement.

INFANT'S NAME:	
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NAME OF FORMULA OFFERED BY PROVIDER OR CENTER:	
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PARENT/GUARDIAN'S REASON FOR FORMULA SUBSTITUTION:	
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NAME OF FORMULA PROVIDED BY PARENT:	
IS THIS FORMULA IRON FORTIFIED?	<input type="checkbox"/> YES <input type="checkbox"/> NO

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____

PROVIDER/CENTER'S RESPONSE TO PARENT REQUEST:	
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PROVIDER/CENTER'S SIGNATURE _____ DATE _____

(Provider: please keep a copy in the child's file and forward the original to your CNP sponsor.)

Date _____

Child's Name _____

Parent's Name _____

Address _____

City, State, Zip _____

Dear Doctor:

The infant listed above is a participant in the Child and Adult Care Food Program (CACFP) which provides federal and state monies to help provide nutritious meals for children in child care centers and day care homes. Children with allergies/intolerances to certain foods, or whose doctors require them to be on foods which are not approved on the CACFP, are required by federal regulation to have a statement from their physician on file with the child care provider or center and CACFP sponsor.

The child care provider or center is offering the food(s) listed on the reverse. If this child has food allergies or intolerances, please complete the information below recommending substitute foods. Please return the form to the parent.

Thank you for your assistance.

CACFP Sponsor _____

Sincerely,

Address _____

City, State, Zip _____

Program Coordinator

Child and Adult Care Food Program

Phone _____

DOCTOR: PLEASE TYPE OR PRINT IN BLACK INK

ALLERGIC TO OR INTOLERANT OF: _____

SUBSTITUTE FOOD: _____

PHYSICIAN'S NAME (PLEASE PRINT): _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S SIGNATURE _____ DATE: _____