Orange County Head Start, Inc.
Empowering Children & Families

FORMULA SUBSTITUTION PHYSICIAN'S STATEMENT

Child's Name _____ **DOB** ____/____/____ **Term**_____

Parent's Name _____ **Parent's Signature** _____
(Permission to release medical information)

Dear Doctor:

The infant listed above is a participant in the Child Care Food Program, which provides federal and state monies to help provide nutritious meals for children in child care centers. Children with allergies/intolerances to formulas, or whose doctors require them to be on formulas which are not approved by 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.

We offer the following formulas: Enfamil with iron or Enfamil Prosobee. If this child cannot tolerate either of the offered formulas, please complete the information below recommending a substitute formula. Please have the parent return this form to school. The child will not be allowed to start school until this needed document is returned.

If you have questions, please call OCHS Nutrition Services at **(714)241-8920** or fax to (**714)632-3543**. Thank you.

Doctor to Complete

1. Medical condition requiring a special formula: _____

_____

2. Reactions from regular infant formulas: (check all the apply)

☐ Diarrhea ☐ Vomiting ☐ Hives/Rash ☐ Constipation ☐ Swelling ☐ Wheezing ☐ Eczema

☐ Other: _____

3. Substitute Formula: _____

4. Special Instructions: _____

_____

5. Comments: _____

_____

_____	_____	(_____)_____	_____
Physician's Printed Name	**Physician's Signature**	**Phone Number**	**Date**

THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER.

Revised 3/18/20