

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 centers 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 CNP requirements, you will need to have him/her complete the back of this form.** 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:	

PARENT/GUARDIAN'S REASON FOR FORMULA SUBSTITUTION:	

NAME OF FORMULA PROVIDED BY PARENT:			
IS THIS FORMULA IRON FORTIFIED?	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">YES</td> <td style="width: 50%; text-align: center;">NO</td> </tr> </table>	YES	NO
YES	NO		

PARENT/GUARDIAN'S SIGNATURE: _____ **DATE:** _____

PROVIDER/CENTER'S RESPONSE TO PARENT'S REQUEST::	

PROVIDER/CENTER'S SIGNATURE: _____ **DATE:** _____

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

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). The USDA is an equal opportunity provider and employer.

Date _____

Child's Name _____

Parent's Name _____

Address _____

City, State, Zip _____

Dear Doctor:

The infant listed above is a participant in a Child Nutrition Program (CNP) 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 foods or formulas, or whose doctors require them to be on foods or formulas which are not approved on the CNP, are required by federal regulation to have a statement from their physician on file with the child care provider or center and CNP sponsor.

The child care provider or center is offering the formula or food listed on the reverse. If this child cannot tolerate the offered formula, or has other food intolerances, please complete the information below recommending substitute formulas or foods. Please return the form to the parent.

Thank you for your assistance.

CNP Sponsor _____

Address _____

City, State, Zip _____

Phone _____

Sincerely,

Program Coordinator
Child Care Food Program

Doctor: Please type or print in black ink

Allergic to or intolerant of: _____

Substitute food or formula: _____

Physician's name (Please print): _____

Physician's Address: _____

Physician's signature: _____ Date: _____