

**MEDICAL AUTHORIZATION OF ALLERGIES, FOOD INTOLERANCES AND
OTHER SPECIAL NEEDS**

CHILD'S NAME _____

ADDRESS _____

DATE OF BIRTH _____

ALLERGY (S)/FOOD INTOLERANCES/SPECIAL NEEDS _____

PARENT OR GUARDIAN SIGNATURE _____

DATE _____

PHYSICIAN'S SIGNATURE _____

DATE _____

Please deliver or mail this form to the attention of :

**CACFP
Southern Adirondack Child Care Network
37 Everts Avenue
Queensbury, NY 12804**

**Our fax number is: 812-0799
Our phone number is: 798-7972**

Thank you for your attention to this matter.

12/2017