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 Ave
Queensbury, NY 12804

OR

CACFP@SACCN.org

Fax # : 518-812-0799
Phone # : 518-798-7972

Thank you for your attention to this matter.