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 email, mail, fax or deliver this form to the attention of:

CACFP
Southern Adirondack Child Care Network
PO Box 593
Glens Falls, NY 12801

Email : CACFP@SACCN.org
Our fax number is: 518- 812-0799
Our phone number is: 518-798-7972

Thank you for your attention to this matter.

06/2022, 01/2024