NORTHEAST SOUTH DAKOTA HEAD START
DIET PRESCRIPTION FOR MEALS

DIRECTIONS FOR PARENT/GUARDIAN:

The parent/guardian: Complete Part 1. ***IF Lactose Free Milk is needed or religious or vegan restrictions are requested*****, a parent signature ONLY is needed (no doctor order needed).**

DIRECTIONS FOR PHYSICIAN:

Complete Part 2, sign and date form.

Return form to: Local Head Start site or mail to: NESD Head Start, 200 S. Harrison #1, Aberdeen, SD 57401 or Fax form to 605-226-0196.

A new prescription is needed if the Physician Ordered restriction is discontinued.

PART 1-TO BE FILLED OUT BY PARENT/GUARDIAN OR LOCAL AGENCY

Child's name: ______________________________________Birthdate:_________________________________

Center/Home Base Name:____________________________ Teacher:__________________________________

Parent/Guardian Name & Phone Number____

Parent Signature____

PART 2-TO BE FILLED OUT BY PHYSICIAN OR PHYSICIAN ASSISTANT:

Food Allergy/Intolerance or Medical Condition:

____

Symptoms:

____

Is this allergy life threatening? _____ Yes _____ No

List food(s) to be omitted and food(s) that may be substituted (Diet Plan):

Foods to Omit:	Foods to Substitute:
_____________________	_____________________
_____________________	_____________________
_____________________	_____________________
_____________________	_____________________
_____________________	_____________________

I certify that the above named child needs special meals prepared as described above because of the child's diagnosis.

Physician name (print) _________________________Physician signature________________________________

Date: _______________________________________ Office phone number______________________________

For Head Start Staff (initial):

______Copy to Cook

______Copy to Teacher/Home Visitor

______Copy to Education Coordinator

______Copy to Family Service Coordinator

______Copy to Health / Nutrition Manager

______Copy to Health Coordinator for Child Health Record

7/15