

Special Diet Prescription

PART 1 – TO BE COMPLETED BY PARENT/GUARDIAN OR LOCAL AGENCY

Child's Name: _____ Birth date: _____

Attendance Center (school, child care, etc.): _____

Parent/Guardian name: _____

Parent/Guardian contact number(s): _____

Parent/Guardian Address: _____

___ I understand that it is my responsibility to submit a new form annually or if medical changes occur.

PART 2- TO BE COMPLETED BY PHYSICIAN

Diagnosis/Disability: _____

___ Food allergy with the risk of anaphylaxis. Please prescribe Epi-Pen for school use.

___ Food intolerance (describe sensitivity): _____

Does the diagnosis/disability restrict the individual's diet: Yes ___ No ___

LIQUIDS TO OMIT

___ Fluid Milk

LIQUIDS TO SUBSTITUTE

___ Water ___ Lactose Free Milk ___ Soy Milk

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 disability/diagnosis. Only a physician licensed under SDCL 36-4 may sign the special diet prescription.

Physician Name (please print) _____ Date: _____

Physician signature _____

Medical Facility _____ Phone: _____

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