Highland Rim Head Start Special Diet Request

Childs Name: __________________________ DOB: ____________________

Medical Provider: _______________________

Address: ______________________________

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Phone Number: _________________________

Fax Number: ___________________________

TO BE COMPLETD BY THE MEDICAL PROVIDER

Diagnosis: ____

(EX. Milk allergy, milk intolerance, vegetarian or religious restrictions)

Identify what items the child may not have: **(EX. Cow's Milk is to be substituted for Soy Milk)**

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(EX.: child may not have milk, pizza, yogurt, cheese, cottage cheese or anything with dairy cooked in the foods)(Pork, beef etc.)

Please specify if not listed above: ____

Specify what substitutions need to be made to accommodate the child: ____________________

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(EX.: soy milk (in place of cow's milk) (vegan meats or fish in place of beef and pork)

Any special equipment required or needed for nutrition reasons:

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Medical Provider Signature: _______________________________________ Date: ___________________

Health Services Manager Signature: __________________________________Date: ___________________

Lead Cook Signature: ____Date: ___________________

Please attach any additional records or information as appropriate or needed.