



Highland Rim Head Start Special Diet Request

Childs Name: _____

DOB: _____

Medical Provider: _____

Address: _____

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)

(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: _____

(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:

Medical Provider Signature: _____ Date: _____

Safety/Nutrition Manager Signature: _____ Date: _____

Lead Cook Signature: _____ Date: _____

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