HIGHLAND RIM HEAD START
Special Diet Request

Child's Name: _____ DOB: _____

Medical Provider: _____

Address: _____

_____

Phone: _____

TO BE COMPLETED BY THE MEDICAL PROVIDER

Diagnosis: _____

Describe the medical or special dietary needs that restrict the child's diet: _____

_____

List food(s) to be omitted from the diet and food(s) that may be substituted (DIET ORDER): _____

_____

_____

Special Equipment: _____

_____

Medical Provider Signature: _____ Date: _____

Please attach any additional records or information as appropriate

Revised 08/08/19