NORTHEAST SOUTH DAKOTA HEAD START
DIET PRESCRIPTION FOR MEALS

DIRECTIONS:

1. **The parent/guardian: complete Part 1.**
2. **The physician: complete Part 2, sign and date form.**
3. **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.**
4. **A new prescription is needed if the restriction is discontinued.**

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

Child's name: _____Birthdate:_____

Center/Home BaseUnit:_____ Teacher:_____

Parent/Guardian name: _____

Parent/Guardian phone:_____

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

Diagnosis : _____

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