Special Diet Prescription Form

Central Services Center – Child Nutrition Services
1101 North Western Avenue
Sioux Falls, South Dakota 57104
(605) 367-7935 Fax (605) 367-7937
Dr. Jane Stavem, Superintendent

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

Child's Name: _____ Birth date: _____

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

Parent/Guardian name: _____

Parent/Guardian contact number(s): _____

Parent/Guardian Address: _____

Parent/Guardian Email Address: _____

Parent/Guardian Signature Required _____ **Date** _____

Initial Box of Understanding

☐ **I understand that it is my responsibility to submit a new form annually if changes in the original special diet prescription.**

"If your child is not currently receiving/served under either an Individualized Education Plan (IEP) or a Section 504 Equal Education Access Plan (504EEAP), this request for a special diet will be considered a consent for a Section 504 evaluation."

PART 2- TO BE COMPLETED BY PHYSICIAN

Describe Condition of Concern: _____

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

_____Food intolerance (describe sensitivity): _____

Does the condition of concern 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 condition of concern. Only a licensed health care professional may sign the special diet prescription. This includes physicians, Certified Nurse Practitioner or Physicians Assistant.

Health Care Professional (Please print name) _____ Date: _____

Health Care Professional Signature _____

Medical Facility _____ Phone: _____

"This institution is an equal opportunity provider"

7/08/2020