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	**LIQUIDS TO SUBSTITUTE**
______Fluid Milk	______ 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"

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