SPECIAL DIET DOCUMENTATION FORM

Child's Name: _____ Center: _____

Dietary regimen/restriction: _____

List all restricted foods: _____

Medical reason: _____

Alternate food/supplements to be provided in place of restricted foods. (Note – This is required when an entire food group is being restricted from the diet):

Other instructions: _____

List any vitamin/mineral supplements, nutritional supplements (i.e. Pediasure, Ensure, etc.) or other relevant medications, which the child is taking):

Is a Registered Dietitian following the child? _____Yes _____ No

If "yes" please list name and phone number:

Physician's Name:

(Print): _____ Phone: _____

_____ _____
Physician's Signature Date

Parent is to sign indicating agreement with the above dietary restrictions.

_____ _____
Parent's Signature Date

Part C: Head Start Staff Acknowledgment: By signing below, I acknowledge my responsibility to ensure the medication for the above-mentioned child is administer as directed in Part A.

Teacher: _____ Family Service Worker: _____

Assistant Teacher: _____ Team Leader: _____