



Provider Name: _____

Date: _____

HDCFS Department
Box 2218
South Dakota State University
Brookings, SD 57007
(605) 688-5730 or 1-800-354-8238

Special Diet Prescription for Meals

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

Child's Name: _____ Birth Date: _____

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

Parent/Guardian name _____

Parent/Guardian contact number(s) _____

PART 2 – TO BE FILLED OUT BY PHYSICIAN

Diagnosis: _____

Describe the patient's disability and the major life activity affected by the disability:

Does the disability restrict the individual's diet: Yes ___ No ___ If yes, list food(s) to be omitted from the diet 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 disability or chronic medical condition.

Physician signature _____ Date: _____

Office phone number _____

For FRN use only:

___ Original sent to FRN

___ Copy Sent to Daycare Provider