



Provider Name: \_\_\_\_\_

Date: \_\_\_\_\_

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

## *Special Diet Request for Meals*

### **PART 1 – TO BE FILLED OUT BY PARENT/GAURDIAN 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 RECOGNIZED MEDICAL AUTHORITY**

Diagnosis: \_\_\_\_\_

Describe the patient's need for special diet:

\_\_\_\_\_  
\_\_\_\_\_

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.

Recognized Medical Authority signature \_\_\_\_\_ Date: \_\_\_\_\_

Office phone number \_\_\_\_\_

**For FRN use only:**

\_\_\_ Original sent to FRN

\_\_\_ Copy Sent to Daycare Provider