PRIME TIME Head Start

Medical Statement for Food Substitutions
Complete Part A OR Part B

STUDENT'S NAME_____
FIRST LAST Date of Birth Current Age

CENTER: MLK Ransom Robinson Thomas & Wilson _____ _____
(Circle one) CLASS # TEACHER(s)

PARENT/GUARDIAN NAME_____ _____
FIRST LAST Relationship to Child

PART A: MEDICAL PROVIDER ONLY

Does this participant have a disability? ☐ Yes ☐ No
If yes, describe major life activities affected by the disability. _____

Does the participant have **special nutritional or feeding needs** related to the disability? ☐ Yes ☐ No

Identify the **medical need for a special diet**: _____

List all foods to be omitted from the child's diet: _____
_____

Does the child require a **Lactose Free Milk Substitute**? ☐ Yes ☐ No
If yes, any specific kind/suggestions? _____

Does the child require a **Milk FREE Substitute**? ☐ Yes ☐ No
If yes, any specific kind/suggestions? ☐ Soy Milk ☐ Rice Milk ☐ Other: _____

WHOLE or BOTH WHOLE & PROCESSED? Please designate whether the food restriction refers to the whole form of the food or both the whole form plus the food found in processed foods.
EXAMPLE: whole eggs or whole eggs plus processed foods containing eggs

- ☐ Whole form of food
- ☐ Whole form of food PLUS food found in processed foods

Does the child require **medication on site for a food allergy or intolerance**? ☐ Yes ☐ No
If yes, Name of Medication(s): _____
(Medication Authorization Required)

Physician, RD or RN signature: _____ Date: _____

PART B: PARENT/GUARDIAN ONLY

Please list all foods you would like to be eliminated from your **child's diet for religious reasons**.

☐ No religious restrictions Yes, please restrict: _____

Parent/Guardian signature: _____ Date: _____

Parent/Guardian must always sign this form Updated: 7/11/20

Fax form to (318) 737-2005 or email to enroll@primetimefamily.org