HIDALGO COUNTY HEAD START PROGRAM
CHILD NUTRITION DEPARTMENT
1901 W. State Hwy. 107 | McAllen, TX 78504

For office use only:
☐ New dietary request
☐ Update dietary request
☐ Renew existing dietary request
☐ Discontinue dieatry request

Medical Statement for Children with Special Dietary Needs

THIS SECTION IS TO BE COMPLETED BY PARENT/GUARDIAN		
Child's Full Name (Last, First, MI):	Date of Birth:	Name of Site:
Name of Parent or Guardian:	Phone Number:	Classroom #:

Authorization to Release Medical Information:
I understand it is my responsibility to renew this form before each school year and anytime my child's nutritional needs change. I authorize the health care provider, to release medical information to the Hidalgo County Head Start Program. The information released will be used for determining issuance of Medical Statement for Children with Special Diets Needs to the above-named child.

Parent or Guardian Signature: _____ Relation to Child: _____ Date: _____

THIS SECTION IS TO BE COMPLETED BY A LICENSED PHYSICIAN/MEDICAL AUTHORITY

Does the child have medical disability which affects one of the major life fuctions that requires meal accommodations?
☐No ☐Yes, if yes, complete PART A. Medical disabilities of this form.

Does the child have a medical or other special dietary need that requires a meal accommodotions?
☐No ☐Yes, if yes, complete PART B. Medical/Special Dietary Needs of this form.

PART A. MEDICAL DISABILITIES

How does this medical disability impact the child's diet?

What meal accommodation(s) are needed to address the child's medical disability?

PART B. MEDICAL/SPECIAL DIETARY NEEDS

Does the child have a food intolerance?
☐No ☐Yes, if yes, complete PART C. Food to be Avoided of this form.

Does the child have a food Allergy?
☐No ☐Yes, if yes, complete PART C. Food to be Avoided of this form.

Is the allergy a life-threating/anaphylactic food Allergy?
☐No ☐Yes

PART C. FOOD TO BE AVOIDED: Please check the food(s) that need be omitted from special diet:

MILK: ☐Avoid fluid milk ☐Avoid all dairy products (fluid milk, cheese, yogurt, ice cream)
☐Avoid milk/milk products, as ingredients in processed or cooked foods

EGG : ☐Avoid whole egg (whites and yolk) ☐Avoid egg yolks only
☐Avoid egg, as an ingredient in processed or cooked foods

SOY: ☐Avoid soy bean protein only ☐Avoid soy protein and soy derivatives (soybean oil/soy lecithin)

☐PEANUTS ☐TREE NUTS ☐FISH ☐SHELLFISH ☐WHEAT ☐SESAME ☐GLUTEN(wheat, rye, barley, etc.)

☐OTHER (please specify):_____

Please indicate appropriate substitution for omitted food(s) above. (You may attach a sheet with additional information as needed.)

TEXTURE MODIFICATION:

Does the child need a texture modification?
☐No ☐Yes, if yes, specify below

Solids: ☐Chopped ☐Finely ground ☐Pureed ☐Other: _____
Liquids: ☐Thickened (Nectar) ☐Thickened (Honey) ☐Thickened (Pudding)

OTHER THERAPEUTIC DIETS (If the child requires special formula or other accommodations not indicated above, please explain below)

Physician's Name	**Printed Name (MD, DO, NO, PA)**	**Date**	**Phone Number**	**Fax Number**