**Family Directed Resources**
**Nutrition Supplement Form**

The family of _____is requesting use of funds to cover special dietary expenses for their child. Please be aware that this program will only cover expenses that relate to a diagnosis that impacts development and nutritional intake.

Client Name: _____ DOB: _____

Parent/Caregiver: _____ Phone #:_____

Diagnosis: _____

What is the nutritional need? _____

Please check which special diet item or nutritional support is needed:

Item:

- ☐ Baby foods/Baby formula beyond 12 months of age
- ☐ Probiotics prescribed for an identified diagnosis
- ☐ Blender or food processor for making pureed foods
- ☐ Gluten free foods prescribed for an identified diagnosis
- ☐ Commercial dietary supplements
  What type: _____
- ☐ Thickening agent
  What type: _____
- ☐ Other: _____

Physician/ Registered Dietician signature: _____ Date: _____