GUSNIP Produce Prescription Script

Guardian Name & Best Contact Number:_____

Interested Participant/Child Name: _____

DOB:_____ (Must be 5-18 years of age)

BMI: _____ Height: _____ Weight: _____

Please put a check mark next to applicable information:

☐ Believe child is Medicaid, CHIP, and/or SNAP eligible

Select current risk(s) and/or qualifying diagnosis:

At Risk for:	Diagnosis of:
☐ anxiety	☐ anxiety
☐ depression	☐ depression
☐ malnutrition	☐ malnutrition
☐ obesity	☐ obesity

Any Additional Comments: _____

_____

_____

(Provider signature) _____

Date of Well Child Exam: _____

Anticipated following year Well Child Exam date: _____