# Ka Ora, Ka Ako | Healthy School Lunches programme

Special Dietary Requirement Form

If your child requires a specialised diet for ethical, religious, or medical reasons, please complete this form in full and return it to the school office.

Please note, specialised diet medical forms may require a signature by a paediatrician, General Practitioner (GP) or registered dietitian.

## PART A- CONTACT DETAILS

|  |  |
| --- | --- |
| **Student Details** | |
| Student Name | Student DoB |
| Class | Year Level |
| **School Details** | |
|  | |
| **Parent/Caregiver Details** | |
| I give permission for the information in this form to be shared with the lunch supplier, for the purpose of providing my child with a safe lunch. | |
| Contact Name | Contact Daytime Phone Number |
| Signature | Date |

## PART B- RELIGIOUS, CULTURAL OR VEGETARIAN/VEGAN DIET REQUIREMENT

|  |  |
| --- | --- |
| **Cultural, religious, or ethical diet (e.g. vegetarian or vegan diet)** | |
| Please specify the type of diet required: | Reason:  Cultural **o**  Religious **o**  Ethical **o** |
| List foods to be avoided: | List of substitute foods: |
| Other relevant information: | |

## PART C - MEDICALLY PRESCRIBED DIET REQUIREMENT

Please indicate the type of medical condition the special diet is to be provided for (please tick all boxes that apply).

|  |  |
| --- | --- |
| **Allergy** | |
| * Peanut **o** * Tree nut (please specify which tree nuts below) **o** * Dairy/Milk Products **o** * Wheat **o** * Egg **o** | * Soy **o** * Fish **o** * Shellfish **o** * Sesame **o** * Kiwifruit **o** |
| Other (Please Specify) **o** | |
| Does your child require an epi pen? Yes**o** No**o** | |
| Does your child know how to use an epi pen? Yes**o** No**o** | |
| **Intolerance** | |
| Gluten Intolerance **o** | Lactose Intolerance **o** |
| Other (Please Specify) | |
| **Other medically prescribed diets – complex special diets** | |
| Crohn’s Disease **o** | Type 1 Diabetes **o** |
| Epilepsy/Ketogenic Diet **o** | Low FODMAP **o** |
| Coeliac Disease **o** | Dysphagia **o** |
| Sensory Aversion (e.g. texture/colour) **o** | Other **o** |
| Does your child require any foods that need changes in texture and state the changes required? Yes **o** No **o** | |
| Do you use prescribed dietary products with your child? Yes**o** No**o** | |
| If yes, do these dietary products go to school with your child? Yes **o** No**o** | |
| If yes to any of the above, please describe what foods or food groups to be avoided and the list of foods that can be used to substitute these: | |

Parent/Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Caregiver Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**To be completed by the school:**

Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Received By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sample Special Diet Medical Form

## TO BE RETURNED TO SCHOOL OFFICE

Date:

Dear:

RE: (Student’s name)

DOB:

NHI Number:

I confirm that the above student requires specialised diet provision.

Diet required:

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

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Any other additional relevant information:

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

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Signed:

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

Consultant/ General Practitioner/ Paediatric dietitian

cc Parents

cc School File

cc Senior Advisor

***MoE Nutritionist Use Only:***

|  |
| --- |
| Category 1 **o** |
| Category 2 **o** |