School/Nursery

*(please print)*

Date of Birth

Name Child/ Young Person

Pupil ref (for school use) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year/Stage \_\_\_\_\_\_\_\_\_\_\_\_

Contact Tel. No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Carer contact email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Restricted Diet**

□ Diabetic □ Dairy Free □ Egg Free □ Gluten Free

□ Lactose Free □ Nut Free □ Other *(please specify in box below)*

Has diet/allergy been referred to or diagnosed by a medical professional? **YES** □ **NO** □

If **YES**, what date was the diagnosis made? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ATTACH A COPY OF DIETICIAN/GP PRESCRIBED DIET SHEET** *(copy attached)* **YES** □

**Other relevant details**

GP Name Hospital

GP Address

Dietician Tel. No.

GP Tel. No.

Dietician Name

Consultant Name

Signature *(Parent/Carer)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature *(Head Teacher)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature *(Catering Services Rep)* ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Return completed form to schools/nurseries who will pass to Catering Services. No change to menus will be made until the form is received and agreed by all parties.**