



# Ka Ora, Ka Ako | Healthy School Lunches programme

## Specialised Diet 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 <input type="checkbox"/> Religious <input type="checkbox"/> Ethical <input type="checkbox"/>
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 specialised diet is to be provided for (please tick all boxes that apply).

Allergy	
<ul style="list-style-type: none"> <li>• Peanut <input type="checkbox"/></li> <li>• Tree nut (please specify which tree nuts below) <input type="checkbox"/></li> <li>• Dairy/Milk Products <input type="checkbox"/></li> <li>• Wheat <input type="checkbox"/></li> <li>• Egg <input type="checkbox"/></li> </ul>	<ul style="list-style-type: none"> <li>• Soy <input type="checkbox"/></li> <li>• Fish <input type="checkbox"/></li> <li>• Shellfish <input type="checkbox"/></li> <li>• Sesame <input type="checkbox"/></li> <li>• Kiwifruit <input type="checkbox"/></li> </ul>
Other (Please Specify) <input type="checkbox"/>	
Does your child require an epi pen? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does your child know how to use an epi pen? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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Intolerance	
Gluten Intolerance <input type="checkbox"/>	Lactose Intolerance <input type="checkbox"/>
Other (Please Specify)	
Other medically prescribed diets	
Crohn's Disease <input type="checkbox"/>	Type 1 Diabetes <input type="checkbox"/>
Epilepsy/Ketogenic Diet <input type="checkbox"/>	Low FODMAP <input type="checkbox"/>
Coeliac Disease <input type="checkbox"/>	Dysphagia <input type="checkbox"/>
Pregnancy or breastfeeding <input type="checkbox"/>	
Does your child require any foods that need changes in texture and state the changes required? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please give further details	
Do you use prescribed dietary products with your child?      Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, do these dietary products go to school with your child?      Yes <input type="checkbox"/> No <input type="checkbox"/>	
For all other medically prescribed diets, 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 by the school: \_\_\_\_\_

By Whom: \_\_\_\_\_

Signature: \_\_\_\_\_