Modified Diet Care Plan

To be completed by the **DOCTOR** or **DIETITIAN** and the PARENT/GUARDIAN
This form is used where a child has a proven history of food allergy or intolerance or requires a special diet for a proven medical condition
This form is confidential and will be available only to supervising staff and emergency medical personnel.

Photo

Child's full name			
Date of birth	/ /	Date for next Review	/ /

Modified Diet form is valid from	/ /	TO	/ /

Medical practitioner authorising diet			
Title / Role			
Authorised Prescriber Signature		Date	

Foods and substances that must be avoided for the period of this plan:
Alternative Foods the person can consume (eg soy products instead of dairy for lactose intolerance)
Can products that state "may contain traces" be consumed?
Yes No
Details of any special feeding routine (eg meals at particular times or intervals for health reasons).
In the case of food allergy/intolerance, what are the signs and symptoms? (Please indicate whether the child can report symptoms, the time period over which symptoms might emerge and the reaction.
First aid response to signs and symptoms of an allergic reaction/intolerance to a food or other substances

I have read, understood and agreed with this plan and any attachments indicated above. I approve the release of this information to supervising staff and emergency medical personnel and agree to this information being displayed

Parent/guardian Name			
Signature		Date	