



## CHILDREN WITH DIETRY REQUIREMENTS

This form is to be completed by the parent of a child with any dietary requirements and returned to the nominated supervisor.

CHILD'S FULL NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SEX: MALE ☐ FEMALE ☐ (PLEASE CHECK BOX) \_\_\_\_\_

Dietary Requirement: \_\_\_\_\_  
\_\_\_\_\_

### Reason (PLEASE USE BLANK SPACES FOR ANY ADDITIONAL SIGNS)

Please note if Medical an Allergy/Chronic Illness form is be completed with a supported Documentation from a Doctor.

|                                |                          |  |
|--------------------------------|--------------------------|--|
| RUBBING FACE AND EYES          | <input type="checkbox"/> |  |
| AGITATED/UNSETTLED             | <input type="checkbox"/> |  |
| REDNESS OF SKIN                | <input type="checkbox"/> |  |
| RASH OR HIVES OVER BODY        | <input type="checkbox"/> |  |
| SORE TUMMY                     | <input type="checkbox"/> |  |
| ITCHY EYES, SNEEZING, COUGHING | <input type="checkbox"/> |  |
| ECZMA                          | <input type="checkbox"/> |  |
| DIARREAH / VOMITING            | <input type="checkbox"/> |  |
| CHOICE                         | <input type="checkbox"/> |  |

Has your child ever experienced an anaphylactic reaction? YES / NO (PLEASE CIRCLE) 8

**\* IF YES PLEASE SPEAK WITH NOMINATED SUPERVISOR OR DIRECTOR IN REGARDS TO ADDITIONAL DOCUMENTS REQUIRED**

If your child suffers from a severe food allergy, an individual management plan will need to be developed in consultation with you. This will include the collection of extensive information.  
If your child's food allergy is not severe is there any other information you would like us to be aware of?

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

PARENTS SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

