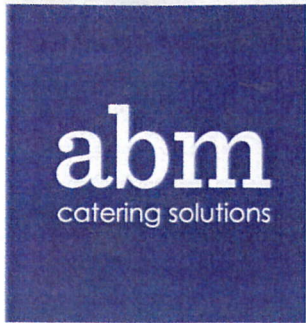


# Special Dietary Needs Form



| Student Information |        |
|---------------------|--------|
| Name:               | Photo: |
| Address:            |        |
| Date of Birth:      |        |
| Class/Form:         |        |
|                     |        |

| Allergy/Intolerance Information |
|---------------------------------|
| Allergy/Intolerance Details:    |
| Symptoms:                       |
| Daily Care Requirements:        |

| Contact Information      |                                  |
|--------------------------|----------------------------------|
| Parent/Guardian Name:    | GP Name:                         |
| Home Telephone Number:   | Telephone Number:                |
| Mobile Telephone Number: | Attached Medical Records: YES/NO |

|                               |
|-------------------------------|
| Signature of Parent/Guardian: |
|-------------------------------|

|                                     |
|-------------------------------------|
| Signature of School Representative: |
|-------------------------------------|

|                          |
|--------------------------|
| Date of Care Plan Issue: |
|--------------------------|

|                           |
|---------------------------|
| Review Date of Care Plan: |
|---------------------------|