

Special Diet Referral Form v2

RAD-F-67



Please hand your completed forms to the School Chef Manager
PLEASE COMPLETE IN BLOCK CAPITALS

Pupil Name: _____ School Name: _____

School Year: _____

Allergy, Intolerance and/or Medical Condition: (please tick one or more boxes)

<input type="checkbox"/> Eggs	<input type="checkbox"/> Cereals containing gluten
<input type="checkbox"/> Dairy	<input type="checkbox"/> Mustard
<input type="checkbox"/> Fish	<input type="checkbox"/> Shellfish
<input type="checkbox"/> Sesame	<input type="checkbox"/> Molluscs , e.g. clams, mussels, whelks, oysters and squid
<input type="checkbox"/> Soya	<input type="checkbox"/> Sulphur dioxide, which is a preservative found in some dried fruit
<input type="checkbox"/> Celery & Celeriac	<input type="checkbox"/> Nuts
<input type="checkbox"/> Lupin	<input type="checkbox"/> Peanuts
<input type="checkbox"/> Coeliac Disease	<input type="checkbox"/> Diabetes

Other (please give details below)

A pupil 'like' or 'dislike' must not be included on this document.

Contact Details Parent/Guardian:
Address:
Postcode:
Phone Number:
Contact Details of Medical Professional:
Name:
Address:
Postcode:
Phone Number:
<input type="radio"/> GP referral letter attached to this document? (This should be attached)
Signature of Parent/Guardian:
Date:

