MINISTRY OF EDUCATION
TE TĀHUHU O TE MĀTAURANGA

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. Please obtain this form from the school office.

PART A- CONTACT DETAILS

Student Details	
Student Name	Student DoB
Class	Year Level
School Details	
St Therese School	
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 ☐ Religious ☐ Ethical ☐
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).

<table>
<tr><th colspan="3">Allergy</th></tr>
<tr><td>• Peanut ☐
• Tree nut (please specify which tree nuts below) ☐
• Dairy/Milk Products ☐</td><td>• Fish ☐
• Shellfish ☐
• Wheat ☐
• Egg ☐</td><td>• Sesame ☐
• Kiwifruit ☐
• Soy ☐</td></tr>
<tr><td colspan="3">Other (Please Specify) ☐</td></tr>
<tr><td colspan="3">Does your child require an epi pen? Yes ☐ No ☐</td></tr>
<tr><td colspan="3">Does your child know how to use an epi pen? Yes ☐ No ☐</td></tr>
<tr><th colspan="3">Intolerance</th></tr>
<tr><td colspan="2">Gluten Intolerance ☐</td><td>Lactose Intolerance ☐</td></tr>
<tr><td colspan="3">Other (Please Specify)</td></tr>
<tr><th colspan="3">Other medically prescribed diets</th></tr>
<tr><td colspan="2">Crohn’s Disease ☐</td><td>Type 1 Diabetes ☐</td></tr>
<tr><td colspan="2">Epilepsy/Ketogenic Diet ☐</td><td>Low FODMAP ☐</td></tr>
<tr><td colspan="2">Coeliac Disease ☐</td><td>Dysphagia ☐</td></tr>
<tr><td colspan="3">Does your child require any foods that need changes in texture and state the changes required? Yes ☐ No ☐</td></tr>
<tr><td colspan="3">If yes, please give further details</td></tr>
<tr><td colspan="3">Do you use prescribed dietary products with your child? Yes ☐ No ☐</td></tr>
<tr><td colspan="3">If yes, do these dietary products go to school with your child? Yes ☐ No ☐</td></tr>
<tr><td colspan="3">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:</td></tr>
</table>

Parent/Caregiver Name: _____

Parent/Caregiver Signature: _____

Date: _____