



## Medically Modified Diet Plan

To be completed by **DOCTOR/DIETICIAN** and the **PARENT/GUARDIAN**. It is to be used where a child **has a proven history of food allergy or intolerance or requires a special diet for a proven medical condition**. This information is confidential and will be available only to supervising staff and emergency medical personnel. Please attach pages if there is not enough space to write details

Childs Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Plan: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medic Alert Number: \_\_\_\_\_ Plan Review Date: \_\_\_\_\_

1. Foods and Substances that must be avoided for the period of this plan:

\_\_\_\_\_

2. Please list in detail alternative foods the child can eat (e.g., soy products instead of standard dairy for lactose intolerance; gluten free products in place of regular breads and cereals)

\_\_\_\_\_

3. Please provide details of any special feeding routine eg. Meals at particular times or intervals for health reasons, providing extra food to meet increased calorie needs

\_\_\_\_\_

4. In the case of food allergy/intolerance, what are the signs and symptoms? Please indicate whether the child can self-report the symptoms, the time period over which the symptoms might emerge and the severity of the anticipated reaction

\_\_\_\_\_

5. Is medication required? **Yes/ No** (If Yes then a Medication Agreement form must be completed by a GP unless an Anaphylaxis Action plan is in place).

6. Does the child have an **Anaphylaxis Care Plan** from a GP? **Yes/ No**

### AUTHORISATION AND RELEASE

#### Doctor or Dietician to Complete

Doctor/Dietician (Please Circle) Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Parent/Guardian to Complete

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

Parent/Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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