Modified diet care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR OR DIETITIAN and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This form is to be used where a person 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.

Name of child/student/client _____ Date of birth _____

Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

Foods and substances that must be avoided for the period of this plan *(see review date above).*

Alternative foods the person can consume *(eg; soy products instead of standard dairy for lactose intolerance).*

Details of any special feeding routine *(eg; meals at particular times or intervals for health reasons).*

In the case of food allergy/intolerance, what are the signs and symptoms?

Please indicate whether the person can report symptoms, the time period over which symptoms might emerge and the severity of the anticipated reaction.

First aid response to signs and symptoms of an allergic reaction/intolerance to a food or other substance.

If the reaction is severe, an anaphylaxis care plan, including an emergency first aid response, will be required from the treating medical practitioner.

AUTHORISATION AND RELEASE

Authorised prescriber _____ Professional role _____

Address _____

Telephone _____

Signature _____ Date _____

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

Parent/guardian

or adult student/client _____ Signature _____ Date _____

Family name (please print) First name (please print)