Hillcrest School

Dietary Requests

If you child requires a special diet as prescribed by a Doctor or has an allergy/intolerance

Pupil Name ____

Does your child have a medically prescribed dietary requirement YES/NO

Do you receive Prescribed Products for your child YES/NO

Please indicate any that apply to your child

Diabetic ☐

Gluten free ☐

Protein free ☐

Nut allergy ☐

Vegetarian ☐

Vegan ☐

Ethnic ☐

Lactose intolerance ☐

Coeliac Disease ☐

Other (specify) ____

Signed (Parent/Carer) ____

Print name ____

Date ____