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 special diet or fluid needs for a proven medical condition
(including a proven history of food allergy or intolerance)

Name of child/student/client ______________________________ Date of birth ____________
Family name (please print) First name (please print)

MedicAlert Number (if relevant) ______________________________ Review date ____________

Description of special dietary or fluid needs.

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Foods, fluids and substances that must be avoided.

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Safe alternative foods that can be consumed if appropriate *(eg lactose free or soy products for lactose intolerance).*

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Details of any special feeding routine *(eg at particular times or intervals for health reasons, or medications to be given with foods).*

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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.

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First aid response to signs and symptoms of an allergic reaction/intolerance to a food or other substance.
Please complete the first aid action plan on the back of this form.
If the reaction is severe, an anaphylaxis care plan, including an emergency first aid response, will be required from the treating medical practitioner. http://www.allergy.org.au/content/view/10/3/

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*** This plan has been developed for the following services/settings:**

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other *(please specify)*

AUTHORISATION AND RELEASE

Health professional ____________________ 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)