Please complete the details below in BLOCK CAPITALS

When you have completed the form please return it to:

Miss Thompson / Ms Waller care plan coordinators

Full name of child/young person	
Class or form	
Does your child have a food allergy?* *(please tick box)* * *If your child is a coeliac (has a wheat allergy), please tick the 'Yes' box.*	☐ Yes, my child/young person has a food allergy and I have attached or will provide you with a doctor's/dietician's assessment of their condition in writing. Please include as much information as possible specific to your child's food allergy. Can he/she tolerate products that say **<u>may contain</u>** for example raw / cooked eggs, nuts (types of) and/or peanuts *I understand that until I have provided you with the medical assessment my child/young person will receive a restricted diet*
	☐ No. My child/young person does not have a food allergy.
Parent/Guardian name	
Relationship to child/young person	
Contact address	
Contact telephone number	
Emergency contact name	
Emergency contact telephone number	
Parent/Guardian signature	I hereby consent to details of my child's / young person's allergy mentioned above and any related doctor's / dietician's assessment being provided by the School to Sodexo Limited for the purpose of preparing and providing appropriate meals for my child / young person.
Date	