

CITY OF EDINBURGH COUNCIL

MEDICAL DIET – SCHOOL MEALS REQUEST FORM

CHILD'S DETAILS

Child's Name..... Date of Birth.....

Address.....

..... Post Code.....

To identify your child it would help if the kitchen had a photo of your child. Please tick the box if you are providing a photo of your child and that you give your consent for it to be displayed in the school kitchen along with their name and dietary requirements. Please note: other school related staff and contractors may have access to the school kitchen. You can withdraw this consent at any time by contacting your school catering team. (Please send photo to your school/nursery kitchen) Please tick to confirm

PARENT / GUARDIAN DETAILS

Contact Name.....

Contact Address.....
(If different from above)

Contact Phone Number.....

In making this request for a medical diet, I acknowledge that whilst employees of the Council will make every reasonable effort to comply with my child's dietary requirements, on occasion, this may not be possible due to the manufacturers' variations to some of their food items.

Signed.....

SCHOOL DETAILS

Name of School

School Address

School year.....

DIETARY DETAILS

Details of Special Dietary Requirements

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HEALTH PROFESSIONAL DETAILS

PLEASE NOTE - THIS REFERRAL MUST BE EITHER SIGNED BY A HEALTH PROFESSIONAL OR ACCOMPANIED BY A DOCTOR'S LETTER

Name of Doctor, Dietitian or Contact Health Professional.....

Signature of Doctor, Dietitian or Contact Health Professional.....

Address.....

.....*Tel No:.....