



**ALLERGIES/DIETARY RESTRICTIONS/MEDICAL/DISABILITY**

We use this information to make sure the needs of our children are being met. If the information changes, please inform the school to make sure it is up to date. For more information about how we use your child's data, visit the Data Protection section of our website.

Name of child:
----------------

Child's GP – Full address	Child's GP - Phone number

**Food Allergies**

I confirm that my child has no food allergies.

OR

My child is allergic to some foods. I understand that school dinners cannot be provided for my child until I have produced medical evidence to support this.

My child is allergic to the following foods, and I will provide medical evidence to confirm:

--	--

**Dietary Restrictions**

I confirm that my child has no dietary restrictions.

OR

I confirm that my child has some dietary restrictions detailed below.

No meat

No fish

No meat and no fish

Other (please provide details below)

**Medical Conditions**

My child has no known medical conditions and does not take any medication.

OR

My child has at least one medical condition.

My child has the following medical condition(s):

---



---

My child has the following prescribed medication:

---



---

### Disability

My child **does not** have a physical or mental impairment that has 'substantial' and 'long-term' negative effect on their ability to do normal daily activities

OR

My child **does** have a physical or mental impairment that has 'substantial' and 'long-term' negative effect on their ability to do normal daily activities

My child is in receipt of Disability Living Allowance

My child has the following physical or mental impairment(s):

<input type="checkbox"/>	Problems with mobility	<input type="checkbox"/>	Problems with hearing
<input type="checkbox"/>	Problems with hand function	<input type="checkbox"/>	Problems with vision
<input type="checkbox"/>	Problems with personal care	<input type="checkbox"/>	Problems with behaviour
<input type="checkbox"/>	Problems with eating and drinking	<input type="checkbox"/>	Problems with consciousness
<input type="checkbox"/>	Problems with medication	<input type="checkbox"/>	Problems with ASD/Aspergers
<input type="checkbox"/>	Problems with incontinence	<input type="checkbox"/>	Problems with palliative care need
<input type="checkbox"/>	Problems with communication	<input type="checkbox"/>	Other disability / health problem – please provide more information
<input type="checkbox"/>	Problems with learning	<input type="checkbox"/>	

I understand that should medical treatment be necessary, every effort will be made to obtain my consent. However, in an emergency I authorise the school to consent on my behalf to any medical treatment, which a medical professional feels is necessary.

I understand that where school or my child have medical concerns, i.e. rashes, sores, pains, irritations, cuts, etc. school staff may need to examine the affected areas or possible affected areas in line with the school's safeguarding policy.

I confirm that the information given is complete and correct. I confirm that the information can be shared with medical professionals in case of emergency. I consent to this information being added to my child's record on the pupil database (SIMS) and being used in anonymised form in the school's Equality Statement.

Parent's Name:	Date:
Parent's Signature:	