Outside School Hours Care
Manly State School

Support Plan for Children with Special Dietary Needs

1. **Personal Details:**
   Child's Surname:_____ Given Names: _____
   Date of Birth:_____ Parent's Name:_____
   Address:_____
   Home Ph:_____ Work Ph:_____ Mobile Ph:_____

2. **Reason for special diet** (Tick Response)
   ☐ religious/cultural ☐ health ☐ other

3. **What foods and substances should the child avoid?**
   _____
   _____

4. **What alternative foods can be used?**
   _____
   _____

5. **How long will the child be on this special diet?**
   _____

6. **Who will provide the food for the child while they are attending OSHC?** (Please circle)
   Breakfast Parent / OSHC Service
   Afternoon Tea Parent / OSHC Service
   Drinks Parent / OSHC Service

7. **Does the child's special diet need any other consideration?** (e.g. eating times, supervision)
   _____
   _____

8. **Do you want to discuss or plan strategies for programs involving food?** (eg. Parties, cooking and food activities)
   _____
   _____

9. **If the child is accidently exposed to food or substances that should be avoided, what would occur?**
   _____
   _____

10. **What action should be taken if the child is accidentally exposed to food or substances that should be avoided?** (eg. Contact parents/doctor, Anaphylactic Action Plan, no action required)
    _____
    _____

Parent Signature: _____ **Date:** _____.