



## DIETARY RESTRICTIONS FORM

Please note that we make every effort to ensure that medically required dietary restrictions are catered for, we cannot however cater to food preferences. If you have a specific medically required diet, please provide the details below.

Name: \_\_\_\_\_

**Indicate which of the following apply to you. You can mark more than one box.**

<input type="checkbox"/>	COELIAC
<input type="checkbox"/>	GLUTEN FREE
<input type="checkbox"/>	DAIRY FREE
<input type="checkbox"/>	LACTOSE INTOLERANCE
<input type="checkbox"/>	DIABETES
<input type="checkbox"/>	VEGETARIAN (no meat or fish)
<input type="checkbox"/>	NO PORK
<input type="checkbox"/>	NO RED MEAT (chicken & fish ok)
<input type="checkbox"/>	NO FISH
<input type="checkbox"/>	VEGAN
<input type="checkbox"/>	PEANUT (anaphylaxis)
<input type="checkbox"/>	NO FRIED OR CRUMBED FOODS

**ALLERGY or INTOLERANCE** (fill in relevant box below)

<b>ALLERGY</b> (an allergy causes rashes, hives, swelling or asthma like symptoms)	List of foods that cause ALLERGY symptoms:
<b>INTOLERANCE</b> (food sensitivity causes digestive issues e.g. pain, diarrhoea, bloating)	List of foods that cause INTOLERANCE symptoms: