

## HEALTH-RELATED DIETARY REQUEST FORM SCHOOL YEAR .....

Municipality of \_\_\_\_\_

- The undersigned (NAME SURNAME) \_\_\_\_\_
- Parent/guardian of (STUDENT NAME SURNAME) \_\_\_\_\_
- OR
- The undersigned school worker/teacher \_\_\_\_\_

telephone/mobile (only if clarifications are needed) \_\_\_\_\_

email address (optional) \_\_\_\_\_

Relevant school: School name \_\_\_\_\_ Class \_\_\_\_\_ Section \_\_\_\_\_

☐ NURSERY

☐ PRE-SCHOOL

☐ PRIMARY

☐ LOWER SECONDARY

### Mark the meals eaten at school provided by CIRFOOD

☐ BREAKFAST

☐ MID-MORNING SNACK

☐ LUNCH

☐ MID-AFTERNOON SNACK

### School days

☐ MONDAY

☐ TUESDAY

☐ WEDNESDAY

☐ THURSDAY

☐ FRIDAY

The Undersigned, as identified above:

1. **REQUESTS** for their child/for themselves as a teacher who uses the school meals service that a HEALTH-RELATED DIET is produced for:

☐ A food intolerance to (please specify the food) - a certificate from the relevant GP is therefore attached with a diagnosis and a list of foods to be excluded from the diet:

.....

☐ A food allergy to (please specify the food) - a certificate from the relevant GP is therefore attached with a diagnosis and a list of foods to be excluded from the diet:

.....

☐ **should be considered "LIFE AT RISK"** (needs life-saving medicines as he/she is at risk of serious allergic reactions, hospitalisation or anaphylactic shock)

☐ A metabolic or autoimmune disease (please specify if it is diabetes, coeliac disease, favism, etc.) - a certificate from the relevant GP is therefore attached with a diagnosis:

.....

☐ **should be considered "LIFE AT RISK"** (needs life-saving medicines as he/she is at risk of hospitalisation and serious health risks)

☐ Other (difficulty swallowing and/or chewing, eating disorders, etc.; please indicate the type of diet requested) - a certificate from the relevant GP is therefore attached with a diagnosis and a list of foods to be excluded from the diet:

.....

☐ **CANCELLATION of a health-related diet** - a certificate from the relevant GP is therefore attached prescribing a free diet

CIRFOOD s.c.

Sede Legale

Via Nobel 19, 42124 Reggio Emilia - Casella Postale n° 65 - Tel. 0522 53011 Fax 0522 530100

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Cod. Fisc. e P.IVA 00464110352 - Registro imprese di Reggio Emilia n° 00464110352 - REA RE 132738

CIRFOOD s.c. iscritta all'ALBO SOCIETÀ COOPERATIVE con il numero A109985

Sezione COOPERATIVE A MUTUALITÀ PREVALENTE - categoria COOPERATIVE DI PRODUZIONE E LAVORO

2. **DECLARES**, as indicated on the medical certificate attached, that:

- ☐ the allergen found in traces or at the production factory CAN BE TOLERATED  
☐ the allergen found in traces or at the production factory CANNOT BE TOLERATED

3. **Information on artisan bread (SELF-DECLARATION):**

- 1) the ingredients of BREAD are: wheat flour, yeast and possibly salt and extra virgin olive oil;
- 2) the artisan suppliers CIRFOOD uses declare that this bread contains GLUTEN and might contain traces of the following allergens: CRUSTACEANS, EGGS, FISH, PEANUTS, SOYA, MILK INCLUDING LACTOSE, NUTS, CELERY, MUSTARD, SESAME SEEDS, SULPHUR DIOXIDE AND SULPHITES, LUPINS, MOLLUSCS as at the same plant and possibly on the same processing line, other products are also made containing these allergens (pursuant to EU Reg. 1169/2011, Italian Legislative Decree 109/92, 88/2009 et seq).

Having understood the explanations above, the undersigned **DECLARES that**

- ☐ the allergen found in traces or at the production plant CAN BE TOLERATED  
☐ the allergen found in traces or at the production plant CANNOT BE TOLERATED

**NB. IF THE CONSUMPTION OF PRODUCTS CONTAINING TRACES OF ALLERGENS IS NOT PERMITTED OR IF THE FORM IS NOT COMPLETED, the alternative offered by CIRFOOD is a product free from all the allergens above, i.e. RICE CAKES**

HE/SHE UNDERSTANDS THAT the adopted procedure involves the following:

- **Only certificates from SPECIALISTS are accepted, such as general paediatricians and specialists in allergology and/or metabolic diseases; certificates issued from specialists other than those indicated shall not be accepted** (it is best to use the form "CERTIFICATE WITH THE NECESSARY INFORMATION ON HEALTH-RELATED DIETS FOR SCHOOL CATERING" attached to this document).
- **Declarations are NOT accepted from other healthcare professionals nor are analytical reports without medical certification.**
- **The consumption of foods with traces of allergens is possible ONLY IF EXPRESSLY permitted by a medical certificate, except for bread when a SELF-DECLARATION is allowed from the parent**
- Without specific medical indication any requested health-related diet shall be valid for one school year (from September to June)
- Dietary requests for permanent metabolic and autoimmune diseases, such as diabetes, coeliac disease and favism, are valid for the entire school cycle (e.g. for the whole time spent at the same pre-school, from class 1 to 5 at the same primary school, etc.), even if it is not specified on the medical certificate.
- **A medical certificate must be presented if the diet is to be suspended, supplemented and/or restricted in any way**
- In order to protect users on a health-related diet as best as possible, **changes to the diet are not accepted (integrations and/or restrictions) when communicated verbally or signed as a self-declaration**, neither from teachers or parents.
- We recommend keeping a copy of the following documentation together with the medical certificate in case they need to be presented when attending summer camps.
- The undersigned understands that the documentation provided may be assessed by the local healthcare authority.

*The undersigned declares that the information and data provided in this form is true.*

Place and date

Legible signature

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TO BE COMPLETED BY THE RELEVANT GP - N.B. Only certificates from SPECIALISTS are accepted, such as general paediatricians and specialists in allergology and/or metabolic diseases.

Date \_\_\_\_\_

It is hereby certified that the child \_\_\_\_\_ M ☐ F ☐  
Born on \_\_\_\_\_ suffers from:

☐ **FOOD ALLERGY**

possibility of serious reactions up to **anaphylactic shock** which requires the ready availability of self-injectable adrenaline  
YES ☐ NO ☐

Detected based on the following diagnostic procedures:

- ☐ In vivo tests (e.g.: Prick Test, Prick by Prick)
- ☐ In vitro tests (e.g.: specific IgE, RAST, ISAC)
- ☐ Intestinal biopsy
- ☐ Breath test
- ☐ Oral provocation test

☐ **FOOD INTOLERANCE**

☐ **COELIAC DISEASE**

☐ **METABOLIC DISEASE/ENZYME DEFICIENCY**

☐ **OTHER DISORDER** \_\_\_\_\_

N.B. please note that only medical certifications showing diagnostic tests recognised by the Italian Ministry of Health shall be considered.

A DIET IS THEREFORE REQUESTED WITHOUT THE FOLLOWING FOODS or COVERING THE FOLLOWING DIETARY GUIDELINES

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**Additional specifications**

- ☐ the food or allergen found in traces or at the production factory CAN BE TOLERATED
- ☐ the food or allergen found in traces or at the production factory CANNOT BE TOLERATED

**Duration of the health-related diet**

- ☐ entire school cycle
- ☐ entire school year ☐
- ☐ n\_\_\_\_\_ months ☐

**Stamp and signature of the relevant GP**

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## ALTERNATIVE MEAL REQUEST FORM FOR ETHICAL OR RELIGIOUS REASONS

SCHOOL YEAR .....

Municipality of \_\_\_\_\_

- The undersigned (NAME SURNAME) \_\_\_\_\_
  - Parent/guardian of (STUDENT NAME SURNAME) \_\_\_\_\_
  - OR
  - The undersigned school worker/teacher \_\_\_\_\_
- telephone/mobile (only if clarifications are needed) \_\_\_\_\_
- email address (optional) \_\_\_\_\_

Relevant school: School name \_\_\_\_\_ Class \_\_\_\_\_ Section \_\_\_\_\_

☐ NURSERY      ☐ PRE-SCHOOL      ☐ PRIMARY      ☐ LOWER SECONDARY

### Mark the meals eaten at school provided by CIRFOOD

☐ BREAKFAST    ☐ MID-MORNING SNACK    ☐ LUNCH    ☐ MID-AFTERNOON SNACK

School days      ☐ MONDAY    ☐ TUESDAY    ☐ WEDNESDAY    ☐ THURSDAY    ☐ FRIDAY

The Undersigned, as identified above:

1. **REQUESTS** for their child/for themselves as a teacher who uses the school meals service that an alternative meal is produced on ethical/religious grounds:

- Religious reason
  - ☐ no meat at all
  - ☐ no pork
  - ☐ no beef
  - ☐ other (please specify) \_\_\_\_\_
- Ethical reason
  - ☐ lacto-ovo vegetarian diet (no meat, no fish — but eggs and milk or milk products are allowed)
  - ☐ lacto vegetarian diet (no meat, no fish, no eggs — milk or milk products are allowed)
  - ☐ ovo vegetarian diet (no meat, no fish, no milk or milk products — but eggs are allowed)
  - ☐ vegan diet (no meat, no fish, no eggs, no milk or milk products)

2. If a health-related diet is needed due to an intolerance or allergy, **you must also fill out** the HEALTH-RELATED DIETARY REQUEST FORM and attach the requested documentation

3. The excluded foods indicated above do NOT take into account possible traces of allergens found in the raw materials used

4. The request is considered valid for the entire school cycle

5. The undersigned understands that the documentation provided may be assessed by the local healthcare authority.

*The undersigned declares that the information and data provided in this form is true.*

Place and date

Legible signature

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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