SUPPLEMENTARY WELFARE ALLOWANCE
CHILD DIET SUPPLEMENT

(S.W.A. 9A - October 2011)

To be used in conjunction with SWA 1

For Office Use
Date Received

By Whom

Information given will be treated as strictly confidential.

Please

- Use BLOCK LETTERS
- Have all Relevant Sections Completed

You do not have to complete this form if your child has a Long-Term Illness Book **and** has Cystic Fibrosis **and** has been prescribed a high protein, high calorie diet.
Please submit your child's Long-Term Illness Book with your application.

If your dependent child is aged 18-22, please complete Adult Diet Supplement Form (SWA9) instead.

Section 1: To Be Completed by Parent or Guardian of Child:

Child's Name ______________________

Child's Date of Birth: ______________________

Address ______________________

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Child's P.P.S. Number: | | | | | | | | | |

I wish to claim a diet supplement for my child from the Department of Social Protection.
I request and authorise the appropriate authorised persons to complete Sections 2 and Section 3 overleaf.

Signed: ______________________
PARENT/GUARDIAN

Parent/Guardian P.P.S. Number: | | | | | | | | | |

Date: ______________________

Section 2: Certificate of Prescribed Medical Condition

(To be completed **only** by a Hospital Consultant or Hospital Registrar)

I certify that ______________________________ has been prescribed a specified diet(s) as part of

his/her treatment for the following medical condition(s):

____

Signed: ______________________________ Official Stamp

Hospital Consultant/Hospital Registrar
(Delete as appropriate)

Date: ______________________________ Telephone Number: ______________________

Section 3: Type and Duration of Diet:

(To be completed by a Hospital Consultant, Hospital Registrar, General Practitioner or Qualified Dietician)

The following diet(s) has/have been prescribed (please tick):

1. **Low Lactose, Milk Free Diet** ☐
2. **High Protein, High Calorie Diet** ☐
3. **Altered Consistency (Liquidised) Diet** ☐
4. **Gluten Free Diet** ☐

The duration of the diet is (please tick):

☐ Unlimited

☐ Restricted and is prescribed from (date) ________________ To (date) ____________________

Signed: ______________________________ **Official Stamp**

Hospital Consultant / Hospital Registrar / General Practitioner / Dietician
(Delete as appropriate)

Date: ______________________________ Telephone No. ______________________