Allergy/Food Intolerance/Special Dietary Requirement Information

Child's First Name	Last Name	Date of Birth

Please complete the table below to advise us of foods your child is allergic/intolerant to or strongly dislikes:

Food 1: ______________________________	Food 2: ______________________________	Food 3: ______________________________
Has your child been diagnosed as anaphylactic to Food 1? YES ☐ NO ☐	Has your child been diagnosed as anaphylactic to Food 2? YES ☐ NO ☐	Has your child been diagnosed as anaphylactic to Food 3? YES ☐ NO ☐
Can your child choose to eat this food if they want to? YES ☐ NO ☐	Can your child choose to eat this food if they want to? YES ☐ NO ☐	Can your child choose to eat this food if they want to? YES ☐ NO ☐
Please describe the most likely reaction your child would have if they consumed Food 1: Anaphylaxis Hives / welts / itchiness Stomach-ache Headache Vomiting Other, please specify ___________________________	Please describe the most likely reaction your child would have if they consumed Food 2: Anaphylaxis Hives / welts / itchiness Stomach-ache Headache Vomiting Other, please specify ___________________________	Please describe the most likely reaction your child would have if they consumed Food 3: Anaphylaxis Hives / welts / itchiness Stomach-ache Headache Vomiting Other, please specify ___________________________
Which foods can be substituted for Food 1? ______________________________	Which foods can be substituted for Food 2? ______________________________	Which foods can be substituted for Food 3? ______________________________

Name of parent/guardian:

Signature: Date: