Food Allergy/Intolerance Form

Child's Name _____ DOB _____

Does your child have any food, medication or environmental allergies? *(check all that apply*)

☐ No
☐ Yes – *check all that apply* ☐ Food ☐ Medication ☐ Environmental
Please list and explain:

Does your child's allergy require the Center staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child?
☐ No
☐ Yes - if yes a Medication Administration Form must be completed.

Does your child have any dietary restrictions, including those for medical, cultural or religious reasons?
☐ No
☐ Yes – please explain

_____ _____
Parent/Guardian Signature Date