Medical and Religious/Cultural Food Restrictions — Children & Adults

Participant's Name: ____________________
Participant's Date of Birth: ____________________ Participant's Age: ____________

Emergency Contact Information:
Name: ____________________ Relation to Participant: ____________
Home: ____________ Work: ____________ Cell: ____________

Please list the foods that the participant may not have, list suggested substitutions, and describe the allergic reaction (if applicable).

1. Food Allergy(ies) ☐ Yes ☐ No
Please check all that apply:

☐ wheat ☐ peanuts ☐ tree nuts ☐ milk ☐ fish ☐ eggs ☐ shellfish ☐ soy
☐ other (please list) ____________________

Please list recommended substitutions for foods listed above:
____
____

Must this food(s) be avoided in all forms and/or in even small amounts? ____________

Please describe the participant's typical allergic reaction:
____
____

What actions should we take in the case of an allergic reaction?
____
____

2. Dietary Restrictions (including those for medical, religious, cultural or other reasons)

☐ Yes ☐ No
If yes, what is the nature of the restriction? ☐ Medical ☐ Religious/Cultural

If yes, please list the restricted foods: ____________________

Please list substitutions for foods listed above: ____________________
____

Must this food be avoided in all forms and/or in even small amounts? ____________

Medical Professional Name (please print): ____________________

Medical Professional Signature: ____________________ Date: ________

Parent/Guardian Signature (child care only): ____________________ Date ________