

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 _____