Individualized Plan of Care for Child with Food Restrictions

Child's Name:_____Date of Birth:_____

Child's Address:_____Phone:_____

Health Care provider Name:_____Phone:_____

Health Care Provider's Address:_____

Dear Parent or guardian please check all items that apply below, thank you

1. _____Food Allergy: _____

My child is seeing an allergist: Yes No

My child has been tested for an allergy to the above named foods on:_____

My child tested: positive or negative to the above named foods on that date.

My child has the following signs and symptoms if they consume the above named foods.

_____

_____

My child's health care provider has prescribed an Epi-Pen for my child's allergy ? Yes No

(If yes to this question your health care provider must fill out a medication authorization form)

2. _____Food Intolerance:

My child is not allergic to any foods, but I prefer that he/she not eat or drink the previously listed items due to discomfort these food items have caused my child in the past.

3._____Lactose Intolerance:

My child is lactose intolerant and must take lactaid before consuming any of the above named foods.

4._____Religious Food exclusion:

Due to my religious beliefs I request that my child not be given any of the previously listed food items.

5._____Food Testing: