FOOD ALLERGY/DIETRAY RESTRICTION EMERGENCY PLAN

Please check one: _____*Allergy* _____*Dietary Restriction*

Food Restricted from: _____

Child's Name: _____ Date of Birth: _____

Doctor: _____

Address: _____

Phone: _____ Fax: _____

Please complete one form FOR EACH known Food Allergy/Dietary Restriction child is allergic to:

Possible Symptoms if exposed to this food:

_____

_____

Specific steps to take if the child has an allergic reaction to this food:

_____

_____

Preapproved snacks from home are/located in:

_____

Food ALLERGY plan must be signed and dated by your child's Health Care Professional

By signing below, the parent or guardian of this child gives Grace Lutheran School permission to post the child's food allergy in the classroom and in GLS.

Dr Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Director Signature: _____ Date:_____