**FOOD ALLERGY AND/OR SPECIAL DIETARY REQUIREMENTS**

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| --- | --- |
| Childs Full Name | Childs Date of Birth |
| Food the child must not consume(list each food separately) | Appropriate food substitutions |
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| Describe allergic reactions and symptoms associated with the above allergies |
| Describe the treatment plan for Around the Clock Childcare Center to follow in response to child’s allergic reaction (include names of medications, dosage amounts, and directions on how to administer medications) |
| Other special dietary requirements |
| Other nonfood allergies and their reactions |
| Is there a doctors note on file for allergies? |
| Doctors Name | Address | Phone Number |

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_