The Learning Community

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Dietary Restriction and Care Plan

Medical Reasons

Must be completed and signed by *MD, DO, NP, APN or FNP only*

Child's Name: _____ **DOB** _____/_____/_____

Please exclude the following food/food products from child's diet_____

_____

due to allergy or medical condition. (Please specify level of exclusion: i.e. food may not be listed on ingredients list at all, food may not be listed in the first 5 ingredients on list, etc.)

Supplement the child's diet with the following food/food products: _____

_____

Symptoms of ingesting food/food products: _____

_____

Treatment in event of ingestion (include all procedures, medications with dosages, method of administering medication, etc.)

_____

_____

_____

_____ _____

Medical Caregiver Print Date

_____

Medical Caregiver Signature