Dietary Restriction

Date:_____

Student's Name:_____

DOB: _____

Emergency Contact: _____

Allergies and Restrictions:

Special Diet or Dietary Restrictions: _____

_____

Food Allergies or Intolerances:

_____

_____

Physician overseeing your child's dietary needs:
Name: _____

Telephone: _____

Email: _____

In case of an emergency where food has been digested, what is the course of action All Children Academics should take?

_____

_____

_____

_____

_____

Parent Signature Date

_____

All Children Academics Date