# DIETARY RESTRICTION FORM

CHILD'S NAME: _____ Date of Birth: _____

Doctors Names: _____ Dr.'s phone:_____

What foods are not allowed:

What Happens, if your child does ingest restricted foods:

What needs to be done, if your child ingests the restricted foods:

Is there any medication needed, in case your child is exposed, and what is the procedure:

Do you have any recommendations or suggestions:

What food is safe, or alternatives to certain foods:

_____ _____

Parent Signature Date