



DIETARY ACCOMMODATIONS FORM FOOD INTOLERANCE

No Medical Attention Required

Name of Child: _____ Date of Birth: _____

Name of Parent/Guardian: _____ Phone: _____

Email Address: _____

Parent/Guardian to supply appropriate substitute foods.

Food Intolerance	Substitute Food	Side Effects Observed

* By signing below, I agree that no medication or treatment is required for my child.

Parent/Legal Guardian (print)

Signature

Date

Lead Teacher (print)

Signature

Date

Food Preparer (print)

Signature

Date

Program/Site Supervisor (print)

Signature

Date