CASCADE CHRISTIAN SCHOOLS

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