Individualized Plan of Care for Child with Food Restrictions

Child's Name:_____DOB:_____

Child's Address:_____

Phone:_____

Health Care Provider Name:_____

Health Care Provider's Address:_____

Phone:_____

Food Allergy: _____

My child is seeing an allergist: Yes No

My child has been tested for an allergy to the above named foods on:_____

My child tested: positive or negative to the above named foods on that date.

My child has the following signs and symptoms if they consume the above named foods.
_____
_____
_____

My child's health care provider has prescribed an Epi-Pen for my child's allergy?

Yes No

(If yes to this question, your health care provider must fill out a medication authorization form)

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Food Intolerance:_____

My child is not allergic to any foods, but I prefer that he/she not eat or drink the previously listed items due to discomfort these food items have caused my child in the past.

Lactose Intolerance:_____

My child is lactose intolerant and must take lactaid before consuming any of the above named foods.

Religious Food Exclusion: _____

Due to my religious beliefs I request that my child not be given any of the previously listed food items.

Parent Signature:_____Date:_____

Child Care Health Consultant Signature:_____Date: _____

Child Care Teachers Signatures: