SPECIAL DIET FORM

Medical, Cultural and Spiritual Food Restrictions

Child's Name: ______________________________ DOB: ______________________

Food Allergy

Does your child have a special diet or food restriction? ☐Yes ☐No

Asthmatic? ☐Yes* ☐No **Higher risk for severe reaction*

Please check all that apply:

□ Wheat □ Peanuts □ Tree nuts □ Milk □ Fish □ Eggs □ Shellfish □ Soy

Other:

Please describe your child's typical allergic reaction:

Must this food(s) be avoided in all forms? □Yes □No

Please list recommended substitutions for foods listed above:

Dosage – (medication provided by Parent/Guardian):

Epinephrine: Inject intramuscularly: ☐EpiPen® ☐EpiPen® Jr. ☐Twinject™ 0.3 mg ☐Twinject™ 0.15 mg

Antihistamine:

Medication:	Dose:	Route:

Other:

Medication:	Dose:	Route:

Symptoms

***The severity of symptoms can quickly change. *Potentially life-threatening**

Mouth: Itching, tingling or swelling of lips, tongue	□**Epinephrine**	□**Antihistamine**
Skin: Hives, itchy rash, swelling on face or extremities	□**Epinephrine**	□**Antihistamine**
Gut: Nausea, abdominal cramps, vomiting, diarrhea	□**Epinephrine**	□**Antihistamine**
***Throat:** Tightening of throat, hoarseness, hacking cough	□**Epinephrine**	□**Antihistamine**
***Lung:** Shortness of breath, repetitive coughing, wheezing	□**Epinephrine**	□**Antihistamine**
***Heart:** Thready pulse, low blood pressure, fainting, pale, blueness	□**Epinephrine**	□**Antihistamine**
***Other:**	□**Epinephrine**	□**Antihistamine**
If reaction is progressing (several of the above areas affected) give:	□**Epinephrine**	□**Antihistamine**
If exposed to an allergen, but no symptoms, give:	□**Epinephrine**	□**Antihistamine**

Dietary Restrictions

What is the nature of the restriction? □ Medical □ Cultural □ Spiritual

Please list the restricted foods:

Please list substitutions for foods listed above:

Must this food be avoided at all times? □ Yes □ No
Must this food(s) be avoided in all forms? □ Yes □ No
If no, please explain:

Required Signatures:

Medical Professional Name (please print):	
Medical Professional Signature:	Date:
Parent/Guardian Name: (please print):	
Parent/Guardian Signature:	Date: