

Allergies and Dietary Restrictions Form

Please complete and return to The River for record of your student's allergies and/or dietary restrictions.

STUDENT INFORMATION

Name: _____ DOB: _____

DIETARY RESTRICTIONS

Please check any and all of the following that apply to the student:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Gluten Free | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Casein Free | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> Lactose Intolerant | <input type="checkbox"/> Kosher |
| <input type="checkbox"/> Other: _____ | |

Please list foods the student cannot eat due to religious or health reasons: _____

ALLERGIES

Please list the student's allergies:

Check box upon completion of Permission for Medical Treatment Form

Check box if attaching an Allergy Action Plan

Parent/ Guardian Signature

Date