
# Does your child have any food allergies, special dietary needs or other medical concerns?

**Child's Name:** _____

☐ My child **does not** have any food allergies, special dietary needs or other medical conditions.

☐ My child **does** have a food allergy, special dietary need or other medical condition. **(Please fill out the bottom portion of this form.)**

**Please circle:** Food Allergy Dietary Need Medical

**Please explain:** _____

_____

_____

**Medication Needed?** ☐ **Yes** ☐ **No**

**(Including inhaler, epi pen, daily medications, etc.)**

**If medications are needed, please contact your center director or your child's teacher for additional medication administration forms.**

**Parent Signature** _____

**Date:** _____