Little Raiders Preschool

Food Allergy or Sensitivity Questionnaire

Program Year: _____ Classroom: _____

Child Name: _____ DOB: _____

	Yes	No
Does your child have any food allergies or sensitivity to foods?	☐	☐

Notes: _____

Parent/Guardian Signature _____ Date: _____

If no food allergy or sensitivity exists – DO NOT complete beyond this point.

	Yes	No
Has a doctor told you your child shouldn't eat certain foods? Foods (appearing on menu) will only be omitted with physician documentation.	☐	☐

What food(s) is he/she allergic or sensitive to?

_____

What type of reaction does he/she experience?

_____

	Yes	No
Does he/she have a reaction only when they ingest food?	☐	☐

What should we do in the classroom when this food item is served?

_____

Allergic reaction can be different each time your child comes into contact with the allergen. Allergic reaction occurs in child when allergen is (select all that apply):

☐ Ingested ☐ Contacted ☐ Inhaled

	Yes	No
Does the child have a physician prescribed Epi-pen for this food allergy?	☐	☐

If yes, complete Medical Health Alert.

Name of physician diagnosing condition: _____

Notes: