Food Allergy or Intolerance

Child's Name_____ **Class**_____

*Please tick if your child **cannot** eat the following foods*

Dairy	Gluten	Other
☐ Cows' Milk(Lactose)	☐ Wheat	☐ Fructose
☐ Goats Milk	☐ Rye	☐ Yeast
☐ Rice Milk	☐ Oats	
☐ Soya Milk	☐ Barley	
☐ No Dairy		

☐ Egg	☐ Other Nuts	☐ Sesame
☐ Soy	☐ Fish	☐ Kiwi Fruit
☐ Peanut	☐ Shellfish	☐ Yeast

Others *(please name)*

☐	☐	☐
☐	☐	☐
☐	☐	☐

Dietary Preferences

Please tick as appropriate:

☐ No Pork	☐ Kosher
☐ No Beef	☐ Vegetarian
☐ No Red Meat	☐ Halal

Others *(please name)*

☐	☐	☐
☐	☐	☐
☐	☐	☐

Thank you for your time in completing this form.

Any changes to these dietary requirements must be made in writing to your child's class teacher.

Parent's Name: _____

Signed: _____ **Date:** _____