

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Has your child tried the following foods at home:

	Yes	No	Did they have a reaction, if so what kind?
Peanuts (peanut butter)			
Tree nuts			
Strawberries			
Eggs			
Soy			
Wheat			
Milk			
Honey			

Is there any other food that you do not wish your child have at school?

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date