Embracing Equality and Diversity

Diet Modifications for Children with a Food Allergy or Dietary Preference

Name of Child: _____ **Date of Birth:** _____

Please indicate below:

_____ **(Initial) YES** or **NO** My child needs diet modification for food allergies or dietary preferences.

_____ **(Initial) YES** or **NO** My child does **not** need diet modification for food allergies or dietary preferences.

***If your child does not need diet modifications for food allergies or dietary preferences, please skip to the signature section.**

Include a brief description of the physical or mental impairment that requires a diet modification:

_____

_____

Please check the food group(s) to be omitted. List specific foods to be omitted and suggest substitutions.

FOODS TO OMIT:	**SUGGESTED SUBSTITUTIONS:**
Milk/Diary Products:	
Eggs/Egg Products:	
Wheat/Wheat Products:	
Soy/Soy Products:	
Peanuts / Tree Nuts/ Other Nuts:	
Fish/ Shellfish:	
Beef/ Pork/ Chicken:	
Vegetables/Fruit:	
Other (Please indicate specifically):	

TEXTURE REQUIRED (Please circle): Regular Chopped Ground Pureed Other: _____

Detailed information regarding diet or feeding (attach additional information as needed):

Please indicate if your child requires any (circle): **EpiPen** or **Benadryl**. *Please attach an allergy action plan, medication administration form and bring in the unopened prescribed medication labeled with child's name and physician name. **(REQUIRED).**

By signing below, I certify that the information indicated on this form is true to the best of my ability. I also certify that I will update this form, as needed, if the specific needs of my child in regard to food allergy or dietary preferences changes while my child is enrolled at Hope Grows Child Development Center, LLC.

Signature of Parent/ Guardian Date