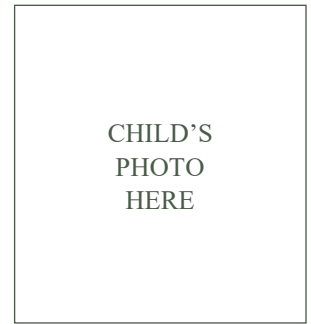


Allergy and/or Dietary Restriction Form

Child's Name
Date of Birth
Health Disclosure <input type="checkbox"/> Allergy* <input type="checkbox"/> Dietary Restriction <input type="checkbox"/> Religious Preference
Description of child's special dietary restriction



**If your child has known allergy, please have your healthcare provider complete the highlighted sections below.*

Description of Allergy / Condition (What physical symptoms does the child exhibit when this food is ingested or if the child comes in contact with this item?)	
Date of last reaction	Action Taken
Please circle all allergy symptoms child has ever experienced Mouth Itching and swelling of lips, tongue or mouth Throat Itching and / or sense of tightness in the throat; hoarseness; hacking cough Skin Hives; itchy rash and / or swelling around the face, arms or legs Stomach Nausea, abdominal cramps, vomiting or diarrhea Lung Shortness of breath; repetitive coughing; wheezing Heart "Thready" pulse; passing out	
Treatment Plan: (Specific action to be taken if child comes in contact with this food / item)	
Name of Medicine _____ Prescription Number _____ Expiration Date _____ Location of Medication in Building _____ Can be kept in school office _____ Should be kept in classroom for urgent administration Dosage Instructions _____ Route of Delivery _____	
Physician's Stamp	
Physician's Signature	Date

I hereby request that Moon Valley Prep, through it'd designated authority, to administer mediation according to the above instruction. I release the school and any school employee from any liability for administering the medication.

Parent's Signature	Date
--------------------	------