H-338

Dietary Action Plan

Child's Name _____ D.O.B. ___/___/___

Check the dietary action plan that applies to this child:

[ ] Please list the restricted foods for the child and the reason for restriction:

_____

_____

_____

[ ] Gluten-Free Diet
[ ] Lactose Intolerant
[ ] Diabetic
[ ] Kosher/Religious
[ ] Other _____

Instructions for staff to follow and steps to take in case of accidental ingestion:

_____

_____

_____

[ ] Accidental ingestion requires no additional steps beyond parent notification.

Call parent/guardian: _____
Phone #

Call Emergency Contact _____
Phone #

_____ __/__/__
Parent's Signature Date

_____ __/__/__
Physician's Signature Date

[ ] Menu alterations have been reviewed/approved by Dietician. _____
Dietician Signature