**Allergy, intolerance or preference**

|  |  |
| --- | --- |
| Child’s name  | Child’s Date of birth  |

Does your child have **(please circle the following the applies):**

|  |  |  |
| --- | --- | --- |
| **Allergy** | **Intolerance** | **Preference** |

|  |
| --- |
| What is the specific allergy, intolerance, or preference:  |

**If your child has an allergy please complete:**

|  |  |
| --- | --- |
| How severe is the allergy/reaction: |  |
| Is your child allergic through touch, smell, or orally? If so, please specify.  |  |
| What treatment is required should an allergic reaction happen? Symptoms of reaction?  |  |
| How many times has your child suffered this allergic reaction?  |  |
| When did your child last experience this reaction?  |  |
| Can you provide any medical information from your GP regarding your child’s allergy?  |  |

**If your child has an intolerance please complete:**

|  |  |
| --- | --- |
| How severe is the intolerance?  |  |

**If you child has a preference please complete:**

|  |  |
| --- | --- |
| Reason for this preference: Religion, parental/carer choice  |  |