

Child's Name _____ Birthday __/__/__ Sex___ Age_____

Food/Drug Allergies_____

Specific Needs in Regards to Food_____

Operations (what/when)_____

Disability/Chronic Illness_____

Is the child taking medication prescribed by a physician now? Yes___ No ___

If so, please list all medications prescribed, the size of does, and when it is taken.

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