



# FOOD ALLERGY/DIETARY RESTRICTIONS

To be filled out by Parent or Guardian

**CONFIDENTIAL**

HH #: \_\_\_\_\_

★ Forms that were completed for your child's current school year with a physician signature may also be submitted in place of this form. ★

The City of Bloomington, Parks and Recreation intends to use the requested information to provide for your child's health and safety while at programming. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health plan for your child. The information you provide will be shared only with staff in the program whose jobs require access to this information to ensure your child's safety.

**Effective Year:** \_\_\_\_\_

**PARTICIPANT**

**FIRST NAME:** \_\_\_\_\_ **LAST NAME:** \_\_\_\_\_

**BIRTH DATE:** \_\_\_\_\_ **Male** **Female**

**HOME PHONE:** \_\_\_\_\_ **CELL #:** \_\_\_\_\_

**FOOD ALLERGY and/or DIETARY RESTRICTION:**

Dietary restrictions are due to:  Allergy  Intolerance  Personal Choice  
 Medical Condition  Religious Restrictions  Other: \_\_\_\_\_

Food preparation:  Is cross contamination a concern? Explain: \_\_\_\_\_

Is concern with uncooked items? Explain: \_\_\_\_\_

Intolerances: List amounts that are okay \_\_\_\_\_

**Asthmatic\*?**  No  Yes Participants with asthma are at risk for more severe reaction.

**ACTION PLAN for MINOR REACTION**

1. If the **only symptom(s)** are \_\_\_\_\_

Give \_\_\_\_\_

\*medication/dose/route/frequency

**Then:**

- 2. Call parents/guardians or emergency contacts.
- 3. If symptoms do not improve in 10 minutes, follow steps for MAJOR REACTION below.

**ACTION PLAN for MAJOR REACTION**

1. If **symptom(s)** are \_\_\_\_\_

Give **EPI PEN®\*** \_\_\_\_\_ **IMMEDIATELY!**

dose/route

Location of Epi Pen®(s): \_\_\_\_\_

**Then call:**

- 2. Rescue 911 (ask for advanced life support)
- 3. Parents/guardians or emergency contacts.
- 4. Stay with participant until paramedics arrive.

Please list any additional information: \_\_\_\_\_

**FOOD ALLERGY and/or DIETARY RESTRICTION**

\* Please complete separate Asthma and/or Medication Form

**OVER**



# FOOD ALLERGY/DIETARY RESTRICTIONS CONTINUED

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**RETURN TO:** City of Bloomington, Parks & Recreation, 1800 W. Old Shakopee Rd,  
Bloomington, MN 55431

## Please do not forget the necessary signatures below.

Effective Year: \_\_\_\_\_

**Physician Signature:**

Only necessary if medication or treatment needed at program

**Date:**

**Form Completed by:**

**Relationship to Participant:**

**Date:**

**Phone:**

The Data Practices Act requires that we inform you or your rights about the private data we are requesting on this form. Private data is available to you, but not to the public. This information can be shared with the Bloomington Parks and Recreation staff. You can withhold this data, but you may not receive updated program information and/or accommodations. Your signature on this form indicates you understand these rights.

**Signature of legal guardian REQUIRED**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**OFFICE ONLY:** Received on \_\_\_\_\_ (date) by \_\_\_\_\_ (Staff)  
RecTrac updated? Y / N Plan Created? Y / N  
Parent/Guardian contacted? Y / N P/G contacted on \_\_\_\_\_ (date)

**Community Services Department** Parks and Recreation Division PH 952-563-8877 parksrec@ci.bloomington.mn.us  
1800 W. Old Shakopee Road FAX 952-563-8715 www.ci.bloomington.mn.us  
Bloomington, MN 55431-3027 TTY 952-563-8740

The City of Bloomington does not discriminate on the basis of disability in the admission or access to, or treatment or employment in, its services, programs, or activities. Upon request, accommodation will be provided to allow individuals with disabilities to participate in all City of Bloomington services, programs, and activities. Upon request, this information can be available in Braille, large print, audio tape and/or computer disk.