Questionnaire for children with allergy

Please print this form and send it signed (pdf-file) to info@ilcielo.de

Child's first name _____

Childs last name _____

Street, Location _____

Contact person _____

Phone number _____ Email _____

Which school is your child in? _____

	Mon	*Tues*	*Wed*	*Thurs*	*Fri*
What days have you booked?	☐	☐	☐	☐	☐

Which kind of food allergy does your child have? _____

_____

Which kind of food intolerance does your child have? _____

_____

Does any genetic disposition exist? _____

Do you have a medical report? _____

Date of medical report _____

Level of lactose intolerance
(please mark)

- Easy ☐
- Medium ☐
- Difficult ☐

In the interest of your childs health, we ask that any changes or adjustments to be made are done immediately and in writing.
Please do not hesitate to contact with any questions. Phone 08153-90 99 78 0

_____

Date/ Parent's signature

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