

DIETARY RESTRICTION FORM

Participant Name _____ Pack Troop Crew # _____

Parent Name _____

Phone _____ Email _____

Camp: Scouts BSA Summer Camp Cub Scout Day Camp Cub Scout Overnight Camp

Webelos & Arrow of Light Overnight Camp Other _____

Camp/Event Dates _____

Please describe the participant's dietary restriction in detail: _____

Allergy Type: Ingestion Contact Airborne Other

If other, please explain: _____

What is the severity of the allergy (i.e. anaphylactic)?: _____

What are the symptoms experienced by the participant if having a reaction?: _____

Is the allergy controlled by medication? Yes No If yes, what medication?: _____

What is the prescribed dosage of the medication? Does the participant have an epi pen?: _____

What are substitution ideas?: _____

Is here any other information you can provide that would be useful to our food service staff?: _____

**Please turn this form in at
the 10-day-out meeting!**

Questions? Please contact:

CHTLeadership@tecumsehCouncil.org

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