# Summer Staff
# Dietary Needs Form

*Please print.*

**For IdRaHaJe to be able to accommodate any food restrictions, your physician must provide their signature in the provided area below.**

Name: ________________________________________________ Birthdate ____/____/_______

Staff Position: ________________________________________

Check any dietary restriction which applies to you:

- ☐ Gluten
- ☐ Dairy
- ☐ Egg
- ☐ Soy
- ☐ Nuts
- ☐ Other:_______________
- ☐ Other:_______________
- ☐ Other:_______________

Explain:______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

***If your dietary restriction is an allergy, please provide additional information on the following:***

Describe any allergic reactions with the food allergen(s) listed above:______________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Do you require an EpiPen? ______________________________________________________________

*If you require an EpiPen, please provide two non-expired EpiPens; one to carry and one to keep in the cabin.*

**I have examined this staff member and can confirm that they require the above dietary restrictions while they are employed at IdRaHaJe.**

**Signature of Physician**____________________________________________ **Date** ___________

Address: __________________________________City ____________ State _____ Zip___________

Phone______________________________