

Form

Name of the child _____

Date of birth _____

Date of the event _____

Phone number _____

Email address _____



FONDATION
PETIT LAPIN

- Allergies
- | | |
|---------------------------------|----------------------------------|
| <input type="checkbox"/> eggs | <input type="checkbox"/> nuts |
| <input type="checkbox"/> dairy | <input type="checkbox"/> peanuts |
| <input type="checkbox"/> soy | <input type="checkbox"/> wheat |
| <input type="checkbox"/> sesame | <input type="checkbox"/> mustard |

Celiac disease yes no

Medical specialist name _____
(allergologist or gastroenterologist)

Medical specialist signature _____

Medical specialist address _____

Parent name if child under 14 _____

Child signature (or parent signature if child under 14) _____

Date of the signature _____

Please complete and return the form at least 2 months before the date of the event to Pâtisserie Petit Lapin (342A Victoria Ave, Westmount, QC H3Z 2M8) or by email to info@patisseriepetitlapin.com.