

# Questionnaire

1. What are the ages of those receiving items? Birthdates?
2. Please list any vegetables you won't or can't eat.
3. Please list any fruits you won't or can't eat.
4. Please list any proteins you won't or can't eat. (Please include avocado and nuts)

## Dietary Needs:

<input type="checkbox"/> Low Sodium	<input type="checkbox"/> Lactose Intolerant	<input type="checkbox"/> Other _____
<input type="checkbox"/> Low Carb	<input type="checkbox"/> Gluten Free	_____
<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Renal	_____
<input type="checkbox"/> Kosher	<input type="checkbox"/> Paleo	_____

## Do you have the following:

<input type="checkbox"/> Oven	<input type="checkbox"/> Can Opener	<input type="checkbox"/> Coffee Pot
<input type="checkbox"/> Stove	<input type="checkbox"/> Microwave	

Do you require non-food items? Please list what you would like added: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Size: (Pads, Tampons, Clothing) \_\_\_\_\_

PIN - \_\_\_\_\_ (4 digits)