

# Food Allergy Form

## Patient Information

Full Name:

Date of Birth:

Age:

Contact Information:

Company/School:

## Medical History

## Food Allergies

**Instructions:** Please tick which food/drink triggers your allergy. Please indicate the cause of the reaction (ingestion, smells, touch), and then indicate the rating of the allergic reaction (mild, moderate, severe/anaphylaxis).

✓	Food/Drink	Cause of reaction?	Severity
	Milk		
	Eggs		
	Fish		
	Crustaceans		
	Tree nuts		
	Peanuts		
	Wheat		
	Soybeans		

	Sesame		
	Pork		
	Beef		

<b>Allergy Symptoms</b>

<b>Intolerances</b>

<b>Special Diet Needs or Restrictions</b>

**Emergency Contacts**

<b>Name and Relationship</b>	<b>Contact Information</b>

**Emergency Plans**

Blank area for writing Emergency Plans.