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		

Allergy Symptoms

Intolerances

Special Diet Needs or Restrictions

Emergency Contacts	
Name and Relationship	**Contact Information**

Emergency Plans