Food Allergy & Special Dietary Need

Name	Age	Male	Female

Email	VP Phone:	Cell/text:

Please check or list all allergies or special dietary needs. Please circle from 1 to 5 severe is the allergy reaction to these foods (1 – uncomfortable 2 3 4 5 – Life Threatening/Serious)

☐ Gluten 1 – uncomfortable 2 3 4 5 – Life Threatening/Serious
☐ Nuts 1 – uncomfortable 2 3 4 5 – Life Threatening/Serious
☐ Dairy 1 – uncomfortable 2 3 4 5 – Life Threatening/Serious
☐ Eggs 1 – uncomfortable 2 3 4 5 – Life Threatening/Serious

Other:

_____
_____
_____

1. Do you have an epi-pen with you? YES NO
2. Did you bring your own food for your meals because of food allergies? YES NO
3. Did you write your name on your own food? YES NO
4. If you did not write your name on your food **PLEASE** write your name on your food.
5. If yes, please write down the name of your special food:

   _____
   _____
   _____

Updated 01/23