# 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 how severe is the allergy reaction to these foods (1 – uncomfortable 2 3 4 5 – Life Threatening)

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

Other:

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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:

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