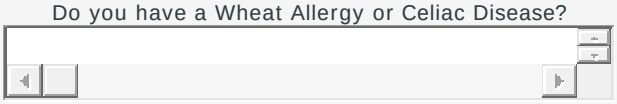
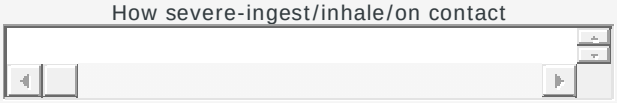
Food Allergy Form: Little Movements Day Care

Student Name Parents Name :	
Parent Contact Phone:	
Parent Contact email:	
Doctor's name & phone # :	
I am allergic/intolerant to:	
Fish:	Which fish? How severe-ingest/inhale/on contact
Shellfish:	Which shellfish? How severe-ingest/inhale/on contact
Tree Nuts:	Which nuts? How severe-ingest/inhale/on contact
Peanuts:	How severe-ingest/inhale/on contact
Milk:	How severe-ingest/inhale/on contact Is it an allergy or an intolerance?
Eggs:	How severe-ingest/inhale/on contact

	
Wheat:	Do you have a Wheat Allergy or Celiac Disease? 
Soy:	How severe-ingest/inhale/on contact 
Do you carry on Epi Pen? yes no	Do you wear a Medic Alert bracelet? www.medicalert.com yes no