Food Allergy, Intolerance, or Dietary Concern Form

PROGRAM INFORMATION

Program Name: _____

Date(s): _____ **Time(s):** _____

Participant Name: _____ Age: _____

Parent/Legal Guardian: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____

Work Phone: _____

Home Phone: _____

Email: _____

Please attach medical documentation from Participant's physician describing the dietary restrictions due to the food allergy or intolerance.

Food Allergy:

- ☐ Dairy
- ☐ Soy
- ☐ Eggs
- ☐ Peanuts
- ☐ Tree nuts
- ☐ Other Please list:
- ☐ Fish
- ☐ Shellfish
- ☐ Wheat (do not check this for celiac disease or gluten sensitivity, only if Participant has a wheat allergy)

Food Intolerance:

- ☐ Gluten (celiac disease or other gluten sensitivity)
- ☐ Lactose
- ☐ Other Please list:

Other dietary concern (please explain):