



teen action & support center

Food Allergies and Intolerances Form

DO NOT complete this form if the teen DOES NOT have a food allergy or special dietary need.

BLS Session Attending: _____

PARTICIPANT INFORMATION:

Participant Name _____ Age _____ Birth Date _____

Parent/Guardian Name _____

Relationship to Participant _____

Phone (cell): _____ Work: _____ Email: _____



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FOOD ALLERGY/INTOLERANCE(S):

*FOOD ALLERGY(S)/INTOLERANCES/Special Diet:

Circle all that apply:

Peanut Wheat Gluten Dairy Shellfish Soy Eggs Fish Tree nuts

Other (please list): _____

Other Special Diet needs or restrictions:

*FOOD INTOLERANCE: ___ Gluten (celiac disease or non-celiac gluten sensitivity, includes wheat, barley, oats, rye) ___ Lactose ___ Fructose ___ Sulfites ___ Histamines ___ Nitrites
___ Fructans ___ Tyramine ___ Galactans ___ Fava Beans ___ MSG ___ Salicylates
___ Polyols ___ Citric acid ___ Nightshades

Other, please list: _____

Dietary Needs Questionnaire

Please answer the following questions to better help us with your needs:

1. What are the preferred food substitutions, if any? (soy butter for peanut butter, gluten free breads, soy milk etc):

2. What types of contact will cause a reaction?

___ Airborne ___ Trace Cross Contact ___ Actual ingestion of food

Please explain:

3. Does the teen understand the food allergy and what needs to be done to manage it?

4. Has the teen ever attended camp or eaten meals outside the home?

If yes, how were the meals handled?



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5. Is there any other information you would like to share to help us meet the teens' needs?

Participant Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____