Allergies Shaped My Life Foundation
Food Allergy Verification

Name of Medical Institute: _____

Address: _____

_____

Phone Number: _____

Applicant Name: _____

Today's Date: _____

Applicant D.O.B. (Optional): _____

Example: (Applicant Name) has confirmed or been diagnosed with (Please List) food allergy(s) or Celiac Disease.

Doctor note verifying food allergy: _____

_____

_____

_____

Physician Name: _____

Physician Signature: _____