IMPORTANT! MUST READ BEFORE TREATING!

Patient's Name: _____

Known Food Allergies

- _____
- _____
- _____
- _____
- _____
- _____

Known Meds Allergies

- _____
- _____
- _____
- _____
- _____
- _____

NOTE: _____

_____

_____

_____

_____

_____

Point of Contact: _____ **Relation:** _____

Cell Phone: _____ **Email:** _____