



**SOUTHEASTERN  
LOUISIANA UNIVERSITY**

**MEDICAL INFORMATION FORM**

**Please complete this form giving all information requested. If anything changes, please notify your student clinician or clinical supervisor so that this form can be updated.**

**Client Name:** \_\_\_\_\_ **File Name:** \_\_\_\_\_

**FOOD ALLERGIES:** Check ***all*** that apply:

Peanuts  Tree Nuts (walnuts, almonds, cashews, pecans)  Wheat  Gluten  Dairy  
 Shellfish  Soy  Eggs  Other: (please list): \_\_\_\_\_  
 None  N/A

**CURRENT MEDICATIONS:** \_\_\_\_\_

**OTHER RELEVANT MEDICAL CONDITIONS:**

Diabetes  Insulin dependent Y/N  Asthma  Seizures  
Other: (Please list): \_\_\_\_\_  
 None  N/A

**IN CASE OF MEDICAL EMERGENCY CONTACT INFORMATION :**

1<sup>st</sup> Contact Person:

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

2<sup>nd</sup> Contact Person:

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

3<sup>rd</sup> Contact Person:

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

**My child has been instructed regarding his/her food allergies including: NEVER to trade food with other people, TELL an adult if symptoms begin, and NEVER go off by him/herself if symptoms begin.**

Parent or Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_