# Allergy Alert Form

**Name:** _____ **Date:** _____

Date of Birth:_____

Person to Contact in Case of an Emergency: _____

Phone Number:_____ Secondary Phone #: _____

Does the client have any known allergies (e.g., to foods, medicines, environmental agents)? ☐ Yes ☐ No
If yes, please list each allergen and descibe the clients response to contact with the allergen(s). _____
_____
_____
_____
_____
_____

Please describe immediate action to be taken in case of contact with allergen(s). _____
_____
_____
_____

Does the client own an Epi- Pen? ☐ Yes ☐ No
If so, will it be available for use during therapy sessions if needed? ☐ Yes ☐ No
Do you give SpeakEasy Therapy Factory permission to administer the Epi- Pen if neccesary? ☐ Yes ☐ No

Person completing form:_____ Relationship to client:_____
Signature:_____ Date:_____ Phone#:_____

**Please return this competed form to SpeakEasy Therapy Factory prior to initial visit via fax or email. Thank you!**

**info@speakeasytherapyfactory.com** **Fax: 803-470-4709** **Phone: 803-400-6334**