Fairfield UNIVERSITY

Food Allergy Support Team; Release of Health Information

I, _____ give my permission to the Fairfield University Student Health Center to obtain and to release health-related information to the University Dining Services, Public Safety Officers (responding Emergency Medical Technicians), Fairfield University Accessibility and the following individuals/organizations. "Health-related information" may include medical history, evaluation, and treatment records. The purpose of this *Release of Health Information* is to facilitate on-campus food allergen avoidance and emergency care of allergic reactions to food.

Please initial and date below next to any individuals/organizations you wish to include on your personal "Food Allergy Support Team."

Individual/Organization	**Initials**	**Date**
Private Physician: Address: Phone:		
Private Allergist: Address: Phone:		
Nutritionist: Address: Phone:		
Parent(s): Address: Phone:		
University Athletic Department, ext. 2273		

Student Signature: _____ Date: _____

Print Name: _____

Student ID#: _____ Date of Birth: _____

Witness Signature: _____ Date: _____

Office Use Only: Dining Services Dietician Notification: Faxed document to Ext. 4042

Clinician Signature: _____ Date: _____