

REQUEST FOR DIETARY ACCOMMODATION

The student named below has applied for an accommodation based on special dietary needs at The University of Scranton. In order to determine the student’s eligibility for reasonable and appropriate accommodations, please provide current and comprehensive information attesting to the student’s disability and documenting the functional impact of the disability. The information you provide will be kept confidential in the student’s CTLE file.

Please take into consideration when completing this form:

1. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting may delay the eligibility review process by necessitating follow up contact for clarification.
2. Healthcare provider should attach any reports which provide additional related information. If a comprehensive diagnosis report is available that provides the requested information, copies of that report can be submitted for documentation as well.

If you have any questions, please call the CTLE at 570-941-4038. Thank you for your assistance.

Student’s Name: _____
(Last) (First) (Middle)

Royal ID: _____ Cell Number: (_____) _____

EMAIL _____

Dining Accommodation Requested: _____ (START) to _____ (END)

Please respond to the following items regarding the above named student:

(Note: A person with a disability is defined as someone who has “a physical or mental impairment that substantially limits one or more major life activities.”)

1. Is this student currently under your care? Yes _____ No _____
2. When did you last see this student? _____
3. What is the diagnosis/medical condition of the student?

a. Date of Diagnosis _____

4. Does this condition/impairment require dietary accommodations? _____

5. Using as much space as needed, please describe the type, severity, and frequency, of symptoms currently experienced by the student, and how the disability interferes with eating or dining in college facilities.

6. Please indicate which modifications you believe are necessary to accommodate the students' medically necessary dietary needs: _____

7. List the student's current medication(s), dosage, frequency, and the adverse effects.

Are there any significant limitations to the student's functioning directly related to prescribed medications?

Yes ____ No ____

If yes, please describe: _____

8. If the student is currently undergoing medical treatment, please describe and indicate how this treatment might impact their dietary choices.

9. Please provide specific dietary recommendations with justification as to why these accommodations will provide greater access to on campus dining for the student.

a. Accommodation: _____

Justification: _____
Necessary _____ Beneficial but not necessary _____

b. Accommodation: _____

Justification: _____
Necessary _____ Beneficial but not necessary _____

10. Any further comments you feel the CTLE should be aware of? _____

Name/Title: _____

Address: _____

Phone: _____

License #: _____ Date: _____

Signature of Provider: _____

Please Note: The provider completing this form cannot be a relative of the student.

Please Return Form to: **The University of Scranton**
 Center for Teaching and Learning Excellence (CTLE)
 800 Linden Street, Scranton, PA 18510
 Phone (570) 941-4038 Fax (570) 941-4154
 Email: disabilityservices@scranton.edu