Request for Dietary Accommodation

PART I: TO BE COMPLETED BY THE STUDENT

Student's Name _____
LAST NAME, FIRST NAME MIDDLE NAME

Date of Birth _____ Cell number _____

Time period requested for dining accommodation _____ to _____
START END

PART II: TO BE COMPLETED BY THE MEDICAL PROVIDER

The student named above 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.

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. The medical 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 as well.
3. The medical provider completing this form cannot be a relative of the student.

If you have any questions, please email non-academic-accom@scranton.edu.

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? (e.g., allergen or dietary trigger such as Crohn's disease, celiac disease, peanut allergy, etc.)

   _____

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

   _____
5. Describe the symptoms related to the student's conditions which substantially limit one or more major life activities.

   _____

6. Please describe the functional limitations resulting from the disability and any information relating to the student's needs that includes the impact of the allergy and its treatment on the student's ability to meet the demands of the college environment.

_____

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

_____

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

○ No ○ Yes. 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 accommodations with justification as to why these accommodations will provide greater access to on campus dining for the student.

Accommodation _____

Justification

_____

○ Necessary ○ Beneficial but not necessary

Accommodation _____

Justification

_____

○ Necessary ○ Beneficial but not necessary

Name/Title _____

Address _____

Phone _____ License number _____

Signature of provider _____ Date _____

By typing your full name you are hereby signing this form.

Please email the completed form to non-academic-accom@scranton.edu or return it to the student so it can be uploaded to the Accommodate system.