THE COLLEGE of IDAHO

REQUEST FOR DIETARY ACCOMMODATION

The student named below has applied for an accommodation based on special dietary needs at The College of Idaho. 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 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.

Student's Name: _______________________ _______________________ ________________________
(Last) (First) (Middle)

Student ID: ______________________________ Cell Number: (_______) _________________________

EMAIL ____

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

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

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.

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

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

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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.

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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: ____

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Justification: ____

Necessary__________ Beneficial but not necessary__________

b. Accommodation: ____

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____

Justification: ____

Necessary__________ Beneficial but not necessary__________

10. Any other information you feel the Office of Learning Support and Disability Services should be aware of? ____

____

____

Provider 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 and direct any questions to:

THE COLLEGE of IDAHO

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www.collegeofidaho.edu