MEAL PLAN ACCOMMODATION VERIFICATON

TO BE COMPLETED BY TREATING HEALTHCARE PROVIDER

Student name: _____ Student DOB:_____

Name of Health Care Provider and business:_____

License Number and state: _____

Credentials and specialty:_____

Address: _____

Phone number: _____ Email: _____

Signature: _____ Date:_____

INSTRUCTIONS

The purpose of this form is to document and assist Ottawa University in supporting students with disabilities with reasonable meal plan accommodations and by providing equal access to the University's dining plan and facility. The residential campuses require all full-time students to have a meal plan. However, occasionally students have dietary limitations based on documented health concerns which might require reasonable accommodations to the meal plan. **Under the Americans with Disabilities Act (ADA), a person is defined as someone who has a physical or mental impairment that substantially limits one or more major life activities.** It is important to note that this is a legal definition, not a medical definition.

Please fill out the form only if you have knowledge based on your professional relationship with the student. This form may be given directly to the student to turn in or may be sent to the ADA/504 Coordinator, Carrie Stevens, at carrie.stevens@ottawa.edu. Please call if you have any questions: 785-248-2326.

PLEASE SUBMIT ANSWERS TO THE FOLLOWING QUESTIONS

Based on the definition above, is this student a person with a disability? If yes, please state the medical diagnosis or condition.

_____

_____

_____

_____

Is this condition permanent? If not, what is the expected duration?

_____

Was this diagnosis made by you? If yes, please state the date of diagnosis. If no, please state the name of the medical professional who provided the diagnosis.

_____

How long has this student been under your care?_____

What is the date of your most recent evaluation of this student?_____

Please describe the type, severity, and frequency of symptoms experienced by this student and how the disability interferes with the student participating in the University's meal plan and/or eating in the University's dining facility. If more space is needed, please attach a separate document or use the bottom of this form.

_____
_____
_____
_____

Please specify the level of sensitivity for all food allergies (*life-threatening anaphylaxis OR high-sensitivity/no anaphylaxis*). Note each allergen under the sensitivity and contact level. For example, if the student has a life-threatening allergy to nuts that can be triggered by airborne contact as well as cross-contamination, you will list "nuts" in section A, under both contact categories. If the student only has a high sensitivity to nuts when consumed, you will list "nuts" under section B, under the contact category for ingesting food. Please explain where necessary. Please provide an additional sheet if necessary (or use the extra space at the end of this form).

A. List all allergens causing **life-threatening anaphylaxis (student carries epi-pen)** (please list all allergens in this category and note which contact applies.

Due to airborne contact:

_____
_____

Due to cross-contamination:

_____
_____

Due to ingesting food only:

_____
_____

Other (please specify allergen and sensitivity):

_____
_____
_____

B. List all allergens causing **High Sensitivity, no anaphylaxis** (please list all allergens in this category and note which contact applies.

Due to airborne contact:

_____
_____

Due to cross-contamination:

_____
_____

Due to ingesting food only:

_____
_____

Other (please specify allergen and sensitivity):

_____
_____
_____

Describe the requested meal plan accommodation. Please explain how the requested accommodation is necessary to allow equal access to the University's meal plan and facility.

_____
_____
_____
_____
_____

Additionally, mark all that apply if this request is made based on food allergies and/or limitations:

__ gluten-free diet
__ dairy and lactose-free diet
__ specialized diets for gastrointestinal diseases (e.g. Crohn's, Celiac, IBS, etc.)
__ menu-planning consolation with Dining Services staff
__ Other (please specify and describe any modifications you believe are necessary)

_____

_____
_____
_____

If applicable, please provide a list of all foods that must be avoided (categories and/or foods).

_____
_____
_____
_____
_____
_____

Please provide any additional information that may be helpful:

_____
_____
_____
_____
_____
_____
_____
_____