Assumption University

Office of Student Accessibility Services

Disability Verification for Dining Accommodation Requests

Assumption University supports and recognizes the standards set forth in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, and its amendments, which are designed to eliminate discrimination against qualified individuals with disabilities. Assumption is committed to providing equity, access, and inclusion of all students with disabilities within the Assumption University community.

By completing Section I of this form, the student consents to allow their physician/clinician to provide information regarding the student's condition to the University's Accommodations Committee (and if necessary, the Appeals Committee) and consents to discussion by appropriate and qualified staff members of the student's request, condition, and resulting determination with the physician/clinician filling out this form. If multiple physicians/clinicians need to provide information, please fill out multiple forms.

Sections II and III of this form must be completed by an appropriate qualified professional (such as a treating or diagnosing health professional). Forms completed by a family member are not acceptable. All accommodation requests will be evaluated on a case-by-case basis. Please note a diagnosis alone does not necessarily qualify the student for the requested accommodation(s). The documentation must also support the need for the accommodation.

Questions should be directed to the chair of the Accommodations Committee, Julie LeBlanc, Senior Director of Student Accessibility and Retention Initiatives at jm.leblanc@assumption.edu.

Section I – STUDENT INFORMATION - *TO BE COMPLETED BY THE STUDENT*

Name: _____ Class Year: _____
First M.I. Last

I hereby give _____ (healthcare provider's name) permission to provide the information requested and to discuss my condition with members of the Accommodations Committee and/or Appeals Committee at Assumption University.

_____ _____
Student Signature (or legal guardian if under 18 years of age Date

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Section II – **PROVIDER INFORMATION -** *TO BE COMPLETED BY THE HEALTHCARE PROVIDER MANAGING THE CONDITION RELEVANT TO THE REQUEST FOR DINING ACCOMMODATION*

Name of Provider: _____

Specialty and License #: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Section III - **MEDICAL INFORMATION** *-TO BE COMPLETED BY THE HEALTHCARE PROVIDER MANAGING THE CONDITION RELEVANT TO THE REQUEST FOR DINING ACCOMMODATION*

Primary Diagnosis: _____

Secondary Diagnosis: _____

How long is the condition(s) expected to last? _____

Describe the symptoms as related to the diagnosis(es): _____

_____

_____

List of current medications and/or treatments used to manage the condition/symptoms: _____

_____

_____

Please share a specific dietary plan/medical nutrition therapy that is part of the student's treatment:

_____

_____

_____

What other supports have been implemented to assist in minimizing or alleviating exacerbation?

_____

_____

_____

Below is a list of common medical dietary needs as outlined by the Mayo Clinic. Please check the box(es) that applies to the student's current dietary requirement.

	Milk Free
	Egg Free
	Peanut/Ground Nut Free
	Tree Nut Free
	Fish Free
	Shellfish Free
	Other:
	Other:

	Soy Free
	Gluten Free
	Wheat Free
	Sesame Free
	Other:
	Soy Free
	Other:
	Other:

Please use the following chart to specify: the dietary needs, severity, associated diagnoses, and the evidence-based method used to determine the diagnoses.

Dietary Need	Is this food allergy or intolerance?	How severe is the allergy or intolerance? (mild, moderate, severe)	Name of diagnosis(es) limiting food intake?	Method used to determine the diagnosis and date of diagnosis?
	☐Food Allergy ☐ Intolerance			
	☐Food Allergy ☐ Intolerance			
	☐Food Allergy ☐ Intolerance			

Healthcare Provider's Signature _____ Date _____