

Accessibility Services 2019-20 Dietary Needs Accommodation Form
Documentation of Food Allergies/Medical Need-To Be Completed By Medical Practitioner

Student's Name: First Last MI Birth Date:

Allergies: Wheat Egg Dairy Peanuts Tree Nuts
 Soy Fish Shellfish
 Conditions: Celiac Disease Crohn's Disease

Other Medical Conditions or Allergies Requiring Dietary Accommodations: _____

Functional Limitations Diet Prescription: Reactions & Food Substitutions

What type of contact will cause a reaction?
 Airborne Trace Contact Indigestion of Food Touching of Food

Severity of Reaction: _____

Treatment Needed: _____

Specific foods that can be substituted or changed; you may attach an additional sheet to further explain.

Recommendation for Dietary Accommodation (Omitted Foods): _____

Food Substitutions: _____

I certify that statements in this document are correct.

Certifying Professional-Please Print and Sign Below.

Provider Name and Credential License Number

Provider Signature Date

Agency Name

Agency Address

Agency Phone Agency Fax