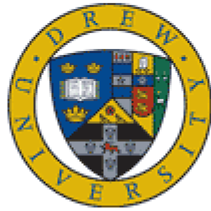


DREW
UNIVERSITY

Dietary Modification Request Form for Students with Disabilities or Food Allergies

Students with food allergies or disabilities that require accommodation or modification to enable them to fully and equally enjoy the privileges, advantages, and accommodations of Drew's food service and meal plan system must complete and submit this form. Drew University will not entertain dietary accommodation requests based on food preference, the desire to prepare one's own meals, or any other reason that cannot be medically verified. Reasonable modification of a student's meal plan is possible only if there is a verifiable medical diagnosis that cannot be met by Drew's food service vendor.

Directions to Students:

- Complete Part I and Identifying Information in Part II
- Sign the Consent for Release of Information in Part I and Part II
- Provide Part II to your qualified healthcare provider
- Both parts must be returned to OAR by July 15th for fall requests or October 31st for spring requests

Part I: Student to complete the following:

Name (please print clearly): ____

Drew ID#: ____

Student Cellular #: ____

Drew Email: ____

Status/Campus: ☐ Incoming Freshman ☐ Transfer ☐ Returning (Year: ____________________)

Accommodation Request is for: ☐ Fall ☐ Spring Year: _______

1. State the disability for which you are requesting a dietary accommodation:

____

____

2. Please explain the dietary accommodation(s) you are requesting.

____

____

3. Have you had this accommodation at Drew University in the past? ______________________

4. Please describe how this accommodation will reduce the impact of your disability.

____

____

____

5. Please add any other information you feel is important for us to consider in reviewing your request.

____

____

____

____

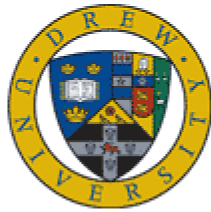
6. Would you like Disability Support Services to contact you regarding disability related academic accommodations or support services? Yes_______ No_______

Student Signature: _____________________________________ Date:_________________

Consent for Release of Information (to be completed by student):

I authorize___________________________(physician or evaluator's name) to disclose the information requested by this form to the office of Accessibility Resources at Drew University for the purpose of evaluating my request for dietary accommodations. I also allow both parties to discuss any information related to my dining/meal plan accommodation request. I understand that my personal medical information will be shared on a "need to know basis" with other university offices.

Student Signature:____Date:___________



All on-campus residence hall students are required to purchase a meal plan. Students with food allergies or disabilities that require accommodation or modification to enable them to fully and equally enjoy the privileges, advantages, and accommodations of Drew's food service and meal plan system must complete and submit this form. Drew University will not entertain dietary accommodation requests based on food preference, the desire to prepare one's own meals, or any other reason that cannot be medically verified. Reasonable modification of a student's meal plan is possible only if there is a verifiable medical diagnosis that cannot be met by Drew's food service vendor.

Name (please print clearly): ____

Date of Birth: _____________ Phone: ________________________

Consent for Release of Information (to be completed by student):

I authorize__________________________(physician or evaluator's name) to disclose the information requested by this form to the office of Accessibility Resources at Drew University for the purpose of evaluating my request for housing accommodations. I also allow both parties to discuss any information related to my dietary accommodation request. I understand that my personal medical information will be shared on a "need to know basis" with other university offices.

Student Signature:____Date:___________

Part II: Physician or Disability Evaluator Verification

PROFESSIONAL EVALUATION OF DISABILITY

You are being asked to provide documentation of disability for your patient. Accommodations are only available to students identified as having a disability. **A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities."** Examples of major life activities are: Major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

1. Based on this definition does the individual have a disability? _________Yes ______ No
   Date of original diagnosis: _____________ Date of most recent evaluation: ________________
   Is the student currently under your care? __________Yes _______ No

2. State the student's disability diagnosis, including diagnostic code.

____

____

3. Describe the type and frequency of symptoms currently experienced by the student due to the condition(s).

____

____

Severity of condition: Mild________ Moderate________Severe_________Other________________

4. What do you foresee as the impact in a college dining hall setting? ___________________________________

____

5. What is the expected duration, stability, or progression of the disability?

____

____

6. Please describe current treatments prescribed.

____

____

7. Is the disability mediated or controlled by medications, other treatments, or external prosthetics? ___Yes ___No
Please explain: ____

8. What **specific** dietary accommodation(s) are necessary due to this condition?

____

____

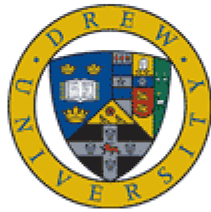
____

9**.** What dietary accommodations do you consider to be preferred but not medically necessary?

____

____

____



DREW UNIVERSITY

THIS SECTION MUST BE COMPLETE FOR FORM TO BE VALID

Physician or disability evaluator INFORMATION (Please Print)

Name: ____

Title: ___________________________ Specialty: ______________________________

Office Address: ____

Phone: ___________________________

License/Certification Number and State of License ____

How long have you treated this patient? ____

Date of most recent office visit? ____

May we contact you if we have questions about this student's accommodation request? _____Yes _______No

Signature: ____ Date:_______________

PLEASE MAIL, FAX or EMAIL COMPLETED FORM TO:
Accessibility Resources
Drew University
36 Madison Ave, Madison, New Jersey 07940
(973) 408-3962 (p), (973) 408-3768(f)
dgiroux@drew.edu