Ferris State University Dining Services

Documentation for Accommodation Needs Form

Reasonable Accommodation requests based on a disability or chronic health condition must be submitted to University Dining Services with information from a licensed clinical professional or health care provider familiar with the student's physical condition(s) and/or restriction. The student, and their guardian if under age eighteen, must fill out page 1 of the form acknowledging the Authorization to Release Health Care Information; the health care provider must fill out the remainder of the form and sign it.

Fax: 231-591-2040
Email: diningad@ferris.edu
Mail: FSU Dining Services
1420 Knollview Dr.
Big Rapids, MI, 49307

To be filled out by the Student

Last, First M.I. _____ Student ID Number _____

Street Address _____

City _____ State _____ Zip _____ Country _____

Authorization to Release Health Care Information: I authorize the provider listed below to release information related to my requested accommodations because of a disability or chronic health condition and to discuss this request with a representative of University Dining and/or Housing, if necessary.

Name of Provider _____ Specialty _____

Address _____ City _____ State _____ Zip _____

I have read and understand the preceding information.

Student Signature _____ Date _____

Legal Guardian Signature (if student is under 18) _____ Date _____

Ferris State University Dining

Have Questions? Contact Ferris Dining Services by e-mail at diningad@ferris.edu or by phone at 231-591-3747.

Full Name _____ **FSU Meal Plan** _____

Local Address _____

Telephone Number _____ **E-Mail Address** _____

STUDENT NOTE: Please fill in the information requested above. Give the form to your physician to complete the following, specifying your dietary needs, and then have your physician fax the form to Dining Services, at 231-591-2040. An appointment will then be set to discuss your specific needs in detail.

FOR PHYSICIAN'S USE ONLY – Please check all that apply

□ Dairy Allergy
□ Lactose Intolerance
□ Wheat Allergy
□ Gluten Intolerance
□ Celiac Disease
□ Egg Allergy
□ Soy Allergy
□ Peanut Allergy
□ Tree Nut Allergy
□ Fish Allergy
□ Shellfish Allergy
□ Diabetes
□ Crohn's Disease
□ Irritable Bowel Syndrome
□ Ulcerative Colitis
□ Oral Surgery
□ Other _____
_____

- What are the patient's possible reactions to the above-indicated allergen(s) or conditions?

- Diet Prescription, omitted foods, and substitutions (may attach additional sheet if necessary)

- What are the medically necessary accommodations to help manage the health of this patient?

- Indicate the length of time a special diet will be required:

  □ Ongoing □ Temporarily from _____ until _____

- Is the patient currently under continuing physician's care? □ Yes □ No
- Date of last visit _____

Printed Name and Title of Physician: _____

Address: _____

License Number: _____

Phone Number: _____-_____-_____ _____

Physician Signature and Date

When completed, please fax to Dining Services, at 231-591-2040

For FSU Dining Use Only

The *Dietary Needs Information Form* was received on _____