FLORIDA ATLANTIC UNIVERSITY

RELEASE OF INFORMATION
FOR VERIFICATION OF A DIETARY DISABILITY/ALLERGY

Student will complete this page and provide it to their clinician. The clinician will complete the verification form.

I, _____, herby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for accommodations.

Student's Signature _____ Phone: _____

Student's Z# _____ Date of Birth: _____

Check the applicable box below to determine how SAS will receive the verification form:

☐ Please return the completed verification form to client/student.

☐ Please return the completed verification form to the Student Accessibility Services office:

☐ Florida Atlantic University- Boca Campus
Student Accessibility Services
777 Glades Road, SU 133
Boca Raton, FL 33431
tel: 561.297.3880 fax: 561.297.2184

☐ Florida Atlantic University- Jupiter Campus
Student Accessibility Services
5353 Parkside Drive, SR 111F
Jupiter, FL 33458
tel: 561.799.8585 fax: 561.799.8819

FLORIDA ATLANTIC UNIVERSITY

STUDENT ACCESSIBILITY SERVICES
DOCUMENTATION FOR A MEAL PLAN ACCOMMODATION

Please complete the form below to assist SAS in determining appropriate and reasonable disability accommodations for dining services. To be considered for a dining services/meal plan accommodation due to allergies or a medical disability, FAU requires documentation of the student's current condition from the treating licensed clinical professional or health care provider.

This form should be completed **ONLY** by the clinician/provider.

Important: *Please note, changing an existing document after it has been signed, faking a signature, or making a false document are all considered to be a forgery.*

CLINICIAN NAME (PRINTED): _____

SIGNATURE OF CLINICIAN: _____

CREDENTIALS: _____ SPECIALTY: _____

LICENSE/CERT. #: _____ STATE_____

DATE: _____

My signature verifies that I am or have been this student's treating health care professional and that all the contents below are true and accurate.

Student Name: _____

1. Disability Diagnosis (DSM-V or ICD-10):

   _____

2. Date of Diagnosis: _____

3. Is this a temporary diagnosis? Yes _____ No _____

If Yes, how long? _____

4. Patient is allergic to: (Please check all that apply or N/A if the disability is not an allergy)

Dairy ☐	Eggs ☐	Wheat/Gluten ☐
Peanuts ☐	Shellfish ☐	Soy ☐
Tree Nuts ☐	N/A ☐	Other (please specify)
		_____

5. What meal plan accommodation is needed and why?

_____

_____

_____

6. 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 facilities.

_____

_____

_____

7. Specify the level of sensitivity for food allergies. Check all that apply.

☐ Life threatening/anaphylaxis (Student carries an epi-pen)
- ☐ Due to airborne contact
- ☐ Due to cross-contamination
- ☐ Due to ingesting food, only
- ☐ Other (please specify) _____

☐ High sensitivity, no anaphylaxis
- ☐ Due to airborne contact
- ☐ Due to cross-contamination
- ☐ Due to ingesting food, only
- ☐ Other (please specify) _____