SUNY Delhi

Access and Equity Services

Resnick Academic Achievement Center
Bush Hall
Phone (607) 746-4596
Fax: 607-832-7593
accessandequity@delhi.edu

Statement for Students Requesting Dietary Accommodations Provider Form

Please type responses or print clearly

This form is to be completed by a qualified healthcare provider (who is not related to the student and is treating the student's condition) with experience and expertise regarding the functional limitations of the student's disability and current symptomology, which would impact the student's dietary needs. Thank you in advance for providing as much detail possible in your responses.

Student Name: _____ Student I.D. #: _____

Date of Birth: _____ Cell Phone: _____

Home Address: _____

SUNY Delhi E-mail Address: _____

Student Status: (Please select one) ☐ Current Student ☐ New Student

FOR MEDICAL DOCTOR USE ONLY

Food allergies and medical conditions (please check all that apply or attach an additional sheet if necessary):

Food allergy to: Dairy ☐ Egg ☐ Fish ☐ Peanut ☐ Wheat ☐ Tree nut ☐ Shellfish ☐ Soy ☐ Gluten ☐ Sesame

Other (Please specify): _____

Please provide the student's diagnosis and the nature of the dietary restriction(s).

_____

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Please describe in detail the symptoms currently experienced by the student.

_____

_____

_____

_____

Length of time under your care_____

Number of consultations with you_____

Dietary Prescription: Restricted Foods and Substitutions

Please list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

Restricted Foods	Substitutions

Indicate length of time special dietary accommodations will be required:

Ongoing ☐ Temporary ☐ (Start date: _____ End date: _____)

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List any special equipment or adaptive utensils needed.

Please provide evidence that the student will not be able to use and enjoy campus dining services with accommodations.

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I certify that the student named above needs special dietary accommodations, as described above, due to the student's food allergies and/or medical conditions.

Provider Name: _____ Date: _____

Provider Signature: _____

Provider License Number: _____ State of Licensure: _____

Provider Address: _____

COMPLETED FORMS
Fax to: 607-832-7593
Mail to:
Gabriella Vasta
Access and Equity Services
221 Bush Hall
454 Delhi Drive
Delhi, NY 13753

Affix business card or apply business stamp within this box