Brandeis University

Medical/Disability Dietary Need Accommodation Review Committee

**Health Provider Report/Form**

**Student should complete the page one consent and then give the Medical Dietary Need Forms to their provider who will return the entire packet to:**

**Brandeis Health Center 415 South Street MS034 Waltham, MA 02453**
**Fax (781) 736-3675 Tel (781) 736-3677**

I, _____ am a current ◯ or entering ◯ student of Brandeis University and am requesting dietary accommodations in the dining hall on the basis of medical diagnosis(es). I understand that Brandeis requires all students living on campus to purchase a meal plan and that this process is to support accommodations within the dining halls so I can meet my medical dietary needs on one of the required meal plans.

I am requesting that my medical/health provider complete the attached Medical Dietary Needs Health Report and supply validating documentation or information as requested by Brandeis University Health Center staff.

I understand that this information may contain information of a confidential nature including medical, psychiatric, and drug or alcohol use information.

This authorization shall remain in effect for 12 months or the duration of the approved accommodations. I understand that this authorization may be revoked at any time by giving written notice to the above address.

I understand that members of the **Medical Dietary Needs Committee** may have access to these documents and information contained in them for the purpose of processing my request and assuring reasonable accommodations.

I am requesting the following medical dietary accommodations (ie dairy free, high protein meals, plain foods etc.) Please note if you will be eating in the Sherman Kosher Dining Hall. :

_____

_____

_____

_____ _____
Students Signature Date Signed

_____ _____
Students Printed Name Date of Birth

**Medical Dietary Needs Health Report Form**
**To be completed and signed by the Health Provider**

**Date Completed:_____**

**Students Name:_____ D.O.B.:_____**
Is the student currently under your care? Yes ◯ No ◯
If yes, how long have you cared for the student? _____

Date of most recent in-person treatment or visit? _____

Please use the following chart to specify the dietary needs, associated diagnoses, and the evidence-based method used to determine the diagnoses. Attach any labs that will help in validating the medical need.

| Dietary Need (From Mayo most common list) | Name of Diagnosis(es) Limiting Food Intake | Is this a Food Allergy or Intolerance? | Evidence- Based Method used to Determine the Diagnosis and Date of Testing |
|---|---|---|---|
| Dairy Free | | | |
| Egg Free | | | |
| Peanut/Ground Nut Free | | | |
| Tree Nut Free | | | |
| Fish Free | | | |
| Shellfish Free | | | |
| Soy Free | | | |
| Gluten Free | | | |
| Other Dietary Needs: | | | |

Please list patients diagnosis (es) :_____
_____
_____
List current medications and treatments used in the treatment of diagnosis(es) as well as anticipated course of treatment:
_____
_____
_____

Describe common symptoms as related to the diagnosis(es):

_____
_____
_____

What circumstances might exacerbate the condition(s) and how was this determined?

_____
_____
_____

What other supports have been implemented to assist in minimizing or alleviating exacerbation?

_____
_____
_____

_____ _____

Physician/Clinician/Therapist signature Printed Name of Clinician

_____

Licensure Type/Clinical Designation

_____

Office Address City State Zip

_____ _____

Office Telephone Office Fax

Please note: General notes, statements, or lists of dietary specifications without specific diagnoses will not be accepted. Documentation from clinician parents/relatives will not be accepted.

To be completed by Health Center Staff:

Health Center Comments on Review:

_____
_____
_____
_____
_____
_____

_____

Signature of Reviewer Title Date