Northampton Community College | Disability Services

3835 Green Pond Road | Bethlehem, PA 18020

Food–Related Disability Verification Form

PLEASE PRINT:

Student's name: _____ Date: _____

Physician/Clinician's name: _____

The above student is requesting accommodations in NCC's Meal Plan under the Americans with Disabilities Act. A meal plan modification will only be considered for students with documented disabilities for whom eating in the dining halls is not viable due to medically required dietary requirements and the capacity of the dining hall to accommodate the student's need. **The licensed health care provider who is treating this patient for the identified diagnosis of a food-related disability must complete this form, and cannot be a family member/relative of the student. Submitted incomplete forms may delay the determination process.**

Please complete this form to document substantial limitations in an academic/residence life environment that stem from a food-related disorder.

1. Diagnosis of Food-related disorder/disability. Provide ICD code:
   _____
   _____
2. Initial date of diagnosis: _____ Date of last clinical visit:_____
3. Assessment instruments used to establish the diagnosis: _____
   _____
   _____
4. The extent of the disorder is: ____ Mild _____ Moderate _____Severe
5. How long is the condition likely to persist:_____
6. Treatments/ medications currently prescribed to mitigate the impact of this condition:
   _____
   _____
7. Describe the functional limitations of this disorder/disability in an academic environment, including residence life:
   _____
   _____
   _____
   _____

8. For food-related conditions, list the specific allergens:_____
   _____
   _____

9. Check off any of the following exposures that trigger a food disorder (allergy) reaction: ___airborne particles ____ skin contact _____ingestion____ cross-contact(contamination) _____Other, please describe:_____

10. The food exposure triggers the following reactions: _____Anaphylaxis _____Angioedema _____ Rash _____Gastrointestinal _____Other, please describe:
    _____

11. Suggestions for potential meal plan accommodations as related to the current disorder; include foods that must be avoided with any appropriate substitutions, contamination, preparation, storage.
    _____
    _____
    _____
    _____

Physician's Signature: _____ Physician's Name: _____

Address: _____

License/Cert #:_____ State: _____

Specialty: _____ Phone: _____

Please affix business card or apply business stamp in the box and return completed form with any supplemental documentation:
FAX: 610-861-5351

EMAIL: disabilityservices@northampton.edu

MAIL: Disability Services-CADS
Northampton Community College
3835 Green Pond Road
Bethlehem, PA 18020

Student Release:

I,_____, authorize the above provider to release the medical information on this form for the purpose of determining eligibility for reasonable and appropriate accommodations based on my request for a Residence Life accommodation at Northampton Community College, and to discuss this request with a representative of NCC's Disability Services and/or Residence Life, including Dining Services, if necessary. I understand all information regarding my request will be protected and kept confidential, except otherwise required by law.

Student signature: _____ Date: _____

NCC ID#_____