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#________________________________________