ENDICOTT COLLEGE

Dietary-Based Disability Documentation Form

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROFESSIONAL

Endicott College is committed to the full participation of students with disabilities in all aspects of College life, including dining experiences. A major facet of living at a residential college is dining together, and the opportunity for developing a sense of community that arises in this setting. To this end, all students living on campus are required to purchase a Meal Plan. Occasionally, students have special needs based on documented health conditions, such as those resulting in certain dietary needs, which may necessitate a dietary accommodation.

Endicott College offers many dining options capable of accommodating many different dietary needs, including but not limited to gluten-free, vegan options and kosher dining, in addition to a wide array of healthy eating choices. All students requesting a meal plan accommodation are asked to first visit with the on-campus dietician for more information on the Dining Hall's allergen program. Please visit https://endicott.sodexomyway.com/contact/feedback to request an appointment. Students will be asked to verify that a consultation with the campus dietician did occur.

Student's Name: _____ **Date of Birth:** _____

Care Provider Information

Provider Name: _____

Credentials: _____

Email: _____

Telephone: _____

Practice Name and Address
(Stamps welcome)

A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities." Examples of major life activities are: seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, thinking, concentrating, learning, reading, communicating, working, performing manual tasks, caring for oneself, and the operation of major bodily functions. A temporary impairment mayinciude an injury, severe iiiness, recovery from surgery, or a condition caused by a traumatic event.

1. **Under the ADA, this individual has a…** *(please select)* ☐ **Disability** **or** ☐ **Temporary Impairment**
2. **Please cite the student's diagnosis:**

Dx #1: _____ Diagnostic code: _____

Dx #2 _____ Diagnostic code: _____

Dx #3 _____ Diagnostic code: _____

From the:

☐ **DSM-IV-TR** ☐ **DSM-V** ☐ **ICD-9** ☐ **ICD-10**

3. **This condition is…**

   ☐ **Permanent**

   ☐ **Temporary. The anticipated duration of the condition is** _____

4. **Date of diagnosis:** _____ **Made by you?** ☐ **Yes**

   ☐ **No, Dx made by:** _____

5. **Number of consultations with you in the past 3 years:** ☐ **Date of your most recent evaluation:** _____

6. **Length of time under your care:** _____

7. **Currently under your care?** ☐ **Yes** ☐ **No, care ended on:** _____

8. **Medical/therapeutic equipment needed:** _____

9. **Describe any relevant side effects of prescription medication(s):**

10. **Using as much space as needed, please describe the type, severity, and frequency of symptoms currently experienced by the student, and how the disability interferes with eating or dining in college facilities.**

11. **Please <u>indicate which modifications you believe are necessary to accommodate the student's medically necessary</u> dietary needs:**

    ☐ Access to the Gluten Free section (including baked goods, soups, sandwiches, etc)

    ☐ Access to the Dairy Free menu options

    ☐ Access to Vegetarian menu options (including seasonal/organic/local produce)

    ☐ Access to Vegan menu options (including seasonal/organic/local produce)

    ☐ Access to Kosher menu options

    ☐ Specialized diets for Gastrointestinal Diseases (e.g., Crohn's, Colitis, IBS)

    ☐ Specialized diets for Diabetes

    ☐ Menu planning consultation with Dining Services Staff

    ☐ Consultation with staff Nutritionist

    ☐ Bulk purchasing program

    ☐ Other (please describe the dietary access modification you believe is necessary):

12. Explain how this alternative to the standard meal plan would affect the student's underlying condition:

13. Any further comments you feel we should be aware of?

14. ☐ **I have attached documentation which led to this diagnosis.**

My signature verifies that I am or have been this student's treating health care professional, that the contents are true and accurate, and that I am not a relative of the student.

Please print and manually sign here

Care Provider's Signature **Date**

This completed form is not to be given to the student. It should be sent directly to Endicott.

Thank you for printing, signing and returning this form to Endicott's Center for Accessibility Services as soon as possible via:

Email:
access@endicott.edu

Fax:
978-338-0643

US Mail:
376 Hale Street, Beverly, MA 01915

Questions? Call: 978-998-7769