Verification of Meal Plan Accommodations/Request for Services

Academic Success Center/Disability Resources

Savitz Hall
201 Mullica Hill Road
Glassboro, NJ 08028
856-256-4259

Please have your Doctor/Practitioner fill out the information below and attach the appropriate supplemental documentation:

Client's Name: _____

Practitioner Name/Title:_____ Date: _____

Address: _____

Telephone: _____ Fax: _____

License or Certification number: _____

Specialty/qualification to make diagnosis: _____

Date of last appointment: _____

To be eligible for services, your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. These laws define a person with a disability as one who (1) has a physical or mental impairment which substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. "Major life activities" are functions such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks, reproduction, and working.

1. Nature of disability with formal diagnosis. Please include expected duration.

_____

_____

_____

2. Severity of condition.

____ MILD ___ MODERATE ___ SEVERE

3. Check all relevant functional limitations are substantially limited.

_____Walking _____Hearing _____Seeing _____Working _____Sleeping _____Caring for self

_____Interacting with others _____Learning (including memory/concentration)

_____Performing manual tasks _____Eating_____ Other, please describe_____

4. List current medication(s), dosage frequency and adverse side effects.

_____

_____

_____

5. Please explain how each functional limitation will specifically affect your client's ability to partake in the University Meal Plan.

_____

_____

_____

6. Please list all foods/ingredients that your client is unable to eat and a **RAST rating for each**. Please explain specifically why each type of food cannot be eaten and whether or not patient uses an EpiPen.

Food: **RAST Rating:** **EpiPen: ___Yes ___No**

_____

_____

_____

7. Please suggest reasonable accommodations and/or modifications to the University Meal Plan. Each recommendation must be supported by the diagnosis. Please discuss the rationale for each suggested accommodation relating it to a specific functional limitation.

_____

_____

_____

8. Please state alternatives to meet the documented need if the first request cannot be met.

_____

_____

_____

9. Please discuss the impact on your client's diagnosis if the accommodation cannot be granted.

_____

_____

_____

10. Additional comments:

_____

_____

_____

Please note: All final decisions on which reasonable accommodations will be granted are made in consultation with the Department of Disability Services for Students, Gourmet Dining (food service provider), Office of Residential Life, and other offices as needed on a case-by-case basis. **At no time is a change in meal plan or removal from the meal plan guaranteed.**

Signature of Specialist: _____ Date: _____