RELEASE OF INFORMATION
FOR VERIFICATION OF A DIETARY DISABILITY/ALLERGY

*Student will complete this page and provide it to their clinician. The clinician will complete the verification form.

I, _____, herby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for accommodations.

1 p q L N _ p ¯ m 1 V T _ A p q l N _____ Phone: _____

1 p q L N _ p ¯ m ? œ _____ Date of Birth: _____

Check the applicable box below to determine how SAS will receive the verification form:

Please return the completed verification form to client/student.

yg 0 G [<0000>] TJ ET Q q 0.0000090 1 111.02 320.45 Tm 0 gdeb-u 1 108.02 320.45 Tm

Florida Atlantic University - Boca Campus
Student Accessibility Services
777 Glades Road, SU 133
Boca Raton, FL 33431
tel: 561.297.3880 fax: 561.297.2184

Florida Atlantic University - Jupiter Campus
Student Accessibility Services
5353 Parkside Drive, SR 111F
Jupiter, FL 33458
tel: 561.799.8585 fax: 561.799.8819

STUDENT ACCESSIBILITY SERVICES
DOCUMENTATION FOR A MEAL PLAN ACCOMMODATION

Please complete the form below to assist SAS in determining appropriate and reasonable disability accommodations for dining services. To be considered for a dining services/meal plan accommodation due to allergies or a medical disability, FAU l N k q V l N m L a J q ^ N _ p A p V a _ a S p U N m p q L N _ p ¯ m J q l l N _ p J a _ L V p V a clinical professional or health care provider.

This form should be completed ONLY by the clinician/provider.

Important: Please note, changing an existing document after it has been signed, faking a signature, or making a false document are all considered to be a forgery.

CLINICIAN NAME (PRINTED) _____

SIGNATURE OF CLINICIAN: _____

CREDENTIALS _____ SPECIALTY _____

LICENSE/CERT. #

If Yes, how long? _____

4. Patient is allergic to: (Please check all that apply or N/A if the disability is not an allergy)

Dairy ___	Eggs ___	Wheat/Gluten ___
Peanuts ___	Shellfish ___	Soy ___
Tree Nuts ___	N/A ___	Other (please specify)
		_____

5. What meal plan accommodation is needed and why?

_____

_____

_____

6. Please describe the type, severity , and frequency of symptoms experienced by this student and how the disability interferes with the student participating in the 4 _ V v N l m V p y ¯ m ^ N A] i] A _ A _ L • a l N A p V _ T V _ p U N 4 _ V v N l m V p

_____

_____

_____

7. Specify the level of sensitivity for food allergies. Check all that apply.

___Life threatening/anaphylaxis (Student carries an epi -pen)
- ___ Due to airborne contact
- ___ Due to cross-contamination
- ___ Due to ingesting food, only
- ___ Other (please specify) _____

___High sensitivity, no anaphylaxis
- ___ Due to airborne contact
- ___ Due to cross-contamination
- ___ Due to ingesting food, only
- ___ Other (please specify) _____