Special Dietary Requests

 **PHONE:** (406) 994-2824 **• FAX:** (406) 994-3943 **•** **EMAIL:** disabilityservices@montana.edu

# FOR STUDENT USE ONLY

Students — please fill in the information requested **in this section only**. After printing, give the form to your physician to complete, specifying your dietary needs. You must upload this form to your ACCOMMODATE portal. **Once this form has been received, an email detailing your next steps will be sent to your email account.**

Full Name Meal Plan (check one) Gold Copper Silver

Last (family) First (given/preferred)

Bronze

Local Address Telephone Number ( ) - - Best Time(s) to Call Email Address Student Year Student ID#

# FOR PHYSICIAN USE ONLY

Physicians — please check all that apply.

Milk Allergy

Soy Allergy

Diabetes

Other (please note)

Lactose Intolerance Wheat Allergy Gluten Free

Celiac Disease Egg Allergy

Peanut Allergy Tree Nut Allergy Fish Allergy Shellfish Allergy Oral Surgery

Diverticular Disease

Crohn’s Disease Irritable Bowel Syndrome Ulcerative Colitis Short Bowel Syndrome

Printed Name and Title of Physician

Address Telephone Number ( ) - -

Physician’s Signature Date

**PHYSICIAN NOTE**

Please answer the following questions using official letterhead of treating physician.

* What are the patient’s possible reactions to the above-indicated allergen(s) or conditions?
* What are the medically necessary dietary accommodations to ensure a safe experience while dining with us? Or why should student be exempt from meal plan?
* What is length of time a special diet will be required Ongoing Temporarily from until
* Is the patient currently undergoing continuing physician’s care? Yes No

# Office of Disability Services Use Only

Dietary Needs Form received on Student appointment set for

Notes: