SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE

ACCESS Dietary Accommodation Physician Verification Form

Section 1: Student Information and Authorization

Student Name: _____

Student 800#: _____ Date: _____

Have you read and reviewed information about special dietary options available on campus? ☐ Yes ☐ No
Have you previously indicated a need for dining accommodation on your housing application? ☐ Yes ☐ No
Have you already met with Dining Services Director and/or chef? ☐ Yes ☐ No

Student Signature: _____

Upon completion by physician, please return to ACCESS office at Southern Illinois University Edwardsville by email or fax.

Section 2: Licensed Provider Information

Name of Provider: _____

Title: _____

Phone Number: _____

License/Certification Number: _____

I certify that the information below is true and accurate.

Signature: _____

Practice Name and Address
(Stamps Welcome)

Information about the Student's Disability

(An individual with a disability is described under section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act (ADA) as a person who has a physical or mental impairment that substantially limits or affects one or more major life activities (i.e. eating, seeing, hearing, etc.) and/or major bodily functions (i.e. digestion, bowel, bladder, immune system, respiratory, endocrine, etc.) *Please be detailed and specific in response to each item as this will assist in evaluating this student's request for dietary accommodation (the provider completing this form should* ***not*** *be a relative of the student).*

☐ Yes, the student is diagnosed with a health condition that limits their ability to eat in the SIUE dining facility.

Medical Diagnosis (i.e., Celiac Disease): _____

Length of time under your care: _____

Description of allergies or food intolerances: _____

Please check any specific allergens/severe food intolerances:

☐ Milk ☐ Eggs ☐ Soy ☐ Fish ☐ Shellfish ☐ Crustacean ☐ Tree Nuts ☐ Peanuts ☐ Wheat

☐ Dairy ☐ Sesame ☐ Mammal Derived Meats ☐ Other: _____

Accessible Campus Community & Equitable Student Support (ACCESS)
t 618.650.3726 **w** siue.edu/access
a Student Success Center, Room 1203, Campus Box 1611, Edwardsville, IL 62026-1611

Please provide a brief description of the major life activity or bodily function that is affected by the disability.

Is there any potential food and medication interaction? Is the student prescribed an EpiPen?

What special diet is required because of this medical condition? (Please include a definitive listing of foods that must be avoided).

Upon completion, please return to ACCESS office at Southern Illinois University Edwardsville by email or fax.