



Return Form

MAIL: Student Accessibility Services
Nazareth University
4245 East Avenue
Rochester, NY 14618
EMAIL: sasoffice@naz.edu
FAX: 585-389-2499

Food Allergy & Special Nutrition Form

PART I. To be completed by student requesting accommodations

Student Name: _____ Student ID: _____

Email Address: _____ DOB: _____ # of credits earned: _____

Current Campus Address: Building: _____ Room #: _____

Home Phone: _____ Cell Phone: _____

Current Academic Level: New Freshman____ New Transfer____ Returning Student____
Which semester are you requesting accommodations: Fall____ Spring____ Summer____

Do you have a medical diagnosis (please explain): _____

If yes, please have your primary care provider fill out the Health Provider Statement in part II

Student's Food Allergy: ___ Dairy ___ Egg ___ Fish ___ Shellfish ___ Soy ___ Wheat
___ Peanuts ___ Tree Nuts ___ Gluten Intolerance ___ Other (please specify): _____

Other medical conditions requiring dietary accommodations (please specify):

List the types of foods you CANNOT or are RESTRICTED from eating: _____

Do you carry an EPI-PEN? ___ YES ___ NO
Is the EPI-PEN carried with you at all times? ___ YES ___ NO
Do you have an ALLERGY or ANAPHYLAXIS Action Plan? ___ YES ___ NO
If yes, please attach a copy.

Student Signature: _____ Date: _____



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PART II. To be completed by the diagnosing/treating healthcare provider

Client/Patient Name: _____

To assist Nazareth University personnel in determining the need for dining accommodations for your patient, please complete the following information. Please be specific in your responses.

1. Are you the primary care physician or a specialist for this student? YES _____ NO _____

2. Diagnosis: _____

3. Original date of diagnosis: _____

4. Patient's Food Allergy: ___ Dairy ___ Egg ___ Fish ___ Shellfish ___ Soy ___ Wheat
___ Peanuts ___ Tree Nuts ___ Gluten Intolerance ___ Other (please specify): _____

5. Medical conditions requiring Dietary Accommodations (please specify and attach documentation including pertinent laboratory/test results supporting the above diagnosis):

6. List the specific types of foods that they CANNOT or are RESTRICTED from eating:

7. List the specific types of foods that they CAN and are ALLOWED to eat: _____

8. Does patient require an Epi-Pen? ___ YES ___ NO

9. Do they self-carry it at all times? ___ YES ___ NO

10. Does patient have an Allergy and Anaphylaxis Action Plan? ___ YES ___ NO

(If yes, please attach).

Provider Information

Name (please print): _____

Title: _____

Address: _____

Phone: _____

Signature: _____

State license #: _____

Thank you!

Please return all materials to:

ATTN: Special Dining Accommodations Committee
Student Accessibility Services
Nazareth University
4245 East Avenue
Rochester, NY 14618
Email: sasoffice@naz.edu
Fax: 585-389-2499