NAZARETH UNIVERSITY

**Return Form**
MAIL: Academic Success & Accessibility
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:

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