Meal Plan Exemption Verification Form

Student's name: _____Date of birth: _____

Physician/Clinician's name: _____

The above student is requesting an exemption from Lakeland University's meal plan under the Americans with Disabilities Act. A meal plan exemption will only be considered for students with documented food-related disabilities for whom eating in the dining hall is not viable due to medically required dietary requirements and the capacity of the dining hall to accommodate the student's dietary needs.

Please complete this form to document substantial limitations in a residence life and campus dining environment that stem from a food-related disorder.

1. Diagnosis of Food-related disorder/disability, including ICD code:

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2. Initial date of diagnosis: _____
3. Date of last clinical visit:_____
4. Assessment instruments and methods used to establish the diagnosis:
   _____
   _____
   _____
5. The extent of the disorder is: ____ Mild _____ Moderate _____Severe
6. How long is the condition likely to persist:_____
7. Treatments/ medications currently prescribed to mitigate the impact of this condition:
   _____
   _____

8. Describe the functional limitations of this disorder/disability, including residence life and campus dining:

_____
_____
_____

9. For food-related conditions, list the specific allergens:

_____
_____

10. Check any of the following exposures that trigger a food disorder reaction:

___ airborne particles ____ skin contact _____ ingestion

___ cross-contact(contamination) ___ other (please describe)

_____
_____

11. The food exposure triggers the following reactions:

_____Anaphylaxis ____ Angioedema _____Rash _____Gastrointestinal

_____Other, please describe:

_____
_____

12. Suggestions for potential meal plan accommodations as related to the current disorder; include foods that must be avoided with any appropriate substitutions, contamination risks, preparation requirements, and storage needs:

_____
_____
_____
_____
_____
_____
_____

13. Please attach a sample 3-day meal plan which would meet the student's dietary restrictions and requirements. Our campus dining staff will use this information to determine their capacity to meet the student's request in full.

Physician's Name:
_____

Physician's Signature: _____

Address:_____

_____

Phone: _____

License/Cert #:_____ State: _____

Please return completed form to:
Lakeland University Disabilities Office
Attn. Karen Eckhardt, ADA Coordinator
W3718 South Drive Plymouth, WI 53073

Phone: 920-565-1021 ext. 2115 Fax: 920-565-1066
Email: EckhardtKL@lakeland.edu

Student Release:

I,_____, authorize the named medical provider to release the information on this form for the purpose of determining eligibility for meal plan exemption at Lakeland University.

I also authorize a representative of Lakeland University Dining Services to review the attached information as part of the exemption request process.

I understand all information regarding my request will be protected and kept confidential, except otherwise required by law.

Student signature: _____ Date: _____