



RELEASE OF INFORMATION
FOR VERIFICATION OF A DIETARY DISABILITY/ALLERGY

*Student will complete this page and provide it to their clinician. The clinician will complete the verification form.

I, _____, hereby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for accommodations.

1 p q L N _ p _ m 1 V T A p q I N _____ Phone: _____

1 p q L N _ p _ m ? œ _____ Date of Birth: _____

Check the applicable box below to determine how SAS will receive the verification form:

Please return the completed verification form to client/student.

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Florida Atlantic University - Boca Campus
Student Accessibility Services
777 Glades Road, SU 133
Boca Raton, FL 33431
tel: 561.297.3880 fax: 561.297.2184

Florida Atlantic University - Jupiter Campus
Student Accessibility Services
5353 Parkside Drive, SR 111F
Jupiter, FL 33458
tel: 561.799.8585 fax: 561.799.8819

**STUDENT ACCESSIBILITY SERVICES
DOCUMENTATION FOR A MEAL PLAN ACCOMMODATION**

Please complete the form below to assist SAS in determining appropriate and reasonable disability accommodations for dining services. To be considered for a dining services/meal plan accommodation due to allergies or a medical disability, FAU clinical professional or health care provider.

This form should be completed **ONLY** by the clinician /provider .

Important : Please note, changing an existing document after it has been signed, faking a signature, or making a false document are all considered to be a forgery.

CLINICIAN NAME (PRINTED) _____

SIGNATURE OF CLINICIAN: _____

CREDENTIALS _____ SPECIALTY _____

LICENSE/CERT. # _____

If Yes, how long? _____

4. Patient is allergic to: (Please check all that apply or N/A if the disability is not an allergy)

Dairy ____

Eggs ____

Wheat/Gluten ____

Peanuts ____

Shellfish ____

Soy ____

Tree Nuts ____

N/A ____

Other (please specify)

5. What meal plan accommodation is needed and why?

6. Please describe the type, severity, and frequency of symptoms experienced by this student and how the disability interferes with the student participating in the

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7. Specify the level of sensitivity for food allergies. Check all that apply.

___ Life threatening/anaphylaxis (Student carries an epi -pen)

___ Due to airborne contact

___ Due to cross-contamination

___ Due to ingesting food, only

___ Other (please specify) _____

___ High sensitivity, no anaphylaxis

___ Due to airborne contact

___ Due to cross-contamination

___ Due to ingesting food, only

___ Other (please specify) _____