

BABSON COLLEGE

Dining Accommodation Request Form

Information for Health Care Professional:

- We will accept documentation from a health care professional who has personal knowledge of the student consistent with their professional obligations. So that we may better evaluate the request for this accommodation, please complete this form in its entirety.
- For **Dining accommodation requests** complete the questions in this form.

Part I:

Student Name:

Date of Birth:

Health Care Professional Who Completed This Form:

Name:

Type of License:

License Number:

Contact Information (phone and/or email):

Signature:

Date:

Part II:

Date of initial consultation:

Date of most recent consultation:

Is this student currently under your care?

Yes

No

Please describe the student's impairment(s) and explain how these impairments substantially limits the student's ability to perform one or more major life activity.

Please state the specific recommendations for reasonable Dining accommodations and explain how the recommended accommodation (s) is necessary.

Is the accommodation request an integral component of a treatment plan

Yes

No

If you answered "yes," please explain:

Part III:

This student is seeking dining accommodations due to a disability. Students seeking dining accommodations must have a diagnosis that makes these dietary modifications medically necessary. Accommodations will not be made regarding personal food preferences.

Food Allergies:

Student is allergic to: (Please check all that apply.)

Dairy

Peanuts

Tree Nuts

Eggs

Shellfish

Wheat/Gluten

Fish

Soy

Other, please specify:

Does the student require an EpiPen?

Yes

No

Is the impact of the disability life-threatening if the accommodation request is not met?

Yes

No

Is there a negative health impact that may be permanent if the accommodation request is not met?

Yes

No

If there is another medical condition that requires dietary accommodations, please specify details here:

Diet Prescription:

Please provide a list of food items that must be omitted from the student's diet and a list of safe and appropriate substitutions.

Length of time dietary accommodations will be required

- Ongoing
- Temporary
- Click to write Choice 3

If Temporary

Start Date

End Date

Please upload any additional laboratory testing or pertinent clinical notes here

Drop files or [click here to upload](#)

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