Disability Resource Center – Meal Accommodation Student Request Form

University of Wisconsin-River Falls • 123 Rodli Hall • River Falls, Wisconsin 54022
office 715.425.0740 • secure fax 715.425.0742

Dining on Campus is an integral part of your college experience and in nearly all cases, specific dietary needs can be met by our dining services. Changes to the meal plan requirements are applied equitably and consistently and are based on medical need. If you have a new or ongoing dietary restriction of a medical nature and are interested in modifying your meal plan, this paperwork is a necessary step in the process.

The information completed on this form will be reviewed to determine:

1. That the student is a person with a documented disability.
2. That the requested accommodation is necessary to afford the student an equal opportunity to use the on-campus housing and/or dining facilities; and
3. That there is an identifiable relationship between the disability and the requested accommodation.

This documentation should be completed after you have submitted a meal plan accommodation request through the Disability Resource Center.

Student's name (please print) _____

Email _____

Phone _____

Current Campus Housing _____

Request is for What Academic Year _____

TYPE OF REQUEST - Please check the type of disability related meal accommodation you are requesting.

_____Reduced Block Plan _____Freddy-To-Go Container _____Consultation with Registered Dietician _____Custom Meals

_____Contract Exemption from Campus Meal Plan _____ Other

What is the reason for your request? Please provide dietary requirements in as much detail as possible to allow the best assessment of your request. Be sure to include history (initial difficulties caused, other accommodations or services you received for it, how any of those changed over time).

_____

_____

_____

_____

_____

Please explain **how the issue has the potential to disrupt important aspects of your college education**. (Important aspects means things like: writing lecture notes; reading textbooks; taking tests; completing assignments; making speeches or presentations; attending class; studying; living in a residential hall, etc.)

_____

_____

_____

_____

_____

What meal plan changes are you requesting? Please explain how this will address the limitations/disruptions described above.

_____

_____

_____

_____

_____

Release of Information*:

- ☐ I authorize University of Wisconsin – River Falls and its representatives to share information related to my *Request for Dietary Accommodations* with relevant departments and individuals. I recognize that the sharing of this information is necessary for departments to work collaboratively for my benefit.

- ☐ I authorize University of Wisconsin – River Falls and its representatives to contact my healthcare provider for additional information, related to this request.

- ☐ I recognize that submission of the *Request for Dietary Accommodation* and accompanying documents does not guarantee a specific request will be granted.

- ☐ I have read this document thoroughly and agree to the process described.

*This release is effective for 1 year from the date of signature.

_____ _____

Student Signature Date

When completed, please fax to **715-425-0742** or send with the student. If you have questions, contact Disability Resource Center professional staff at 715-425-0740, or **drc@uwrf.edu.**

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To Be Completed by the Healthcare Provider

Instructions for Students:
Please complete the *Consent for Release of Information* below and deliver this form to the healthcare provider who is **primarily responsible for treating you for this condition**.

Consent for Release of Information (to be completed by student):
I authorize _____(healthcare provider's name) to disclose the information requested on this form to University of Wisconsin – River Falls and its representatives for the purpose of evaluating my request for a meal plan accommodation. I authorize both parties to discuss information, as needed, related to my request.

*This release is effective for 1 year from the date signed.

Student Name: _____ Date of Birth: _____
Student Signature: _____ Date: _____

Instructions for Healthcare Provider Completing this Form:
The student named above has requested a dietary accommodation at University of Wisconsin – River Falls (UWRF). All students living on campus are required to have a meal plan, unless otherwise granted permission by the University. UWRF may provide meal plan modifications to students with documented medical need. Dietary accommodations vary according to the individual needs of each student and will be determined on a case-by-case basis. In order to effectively evaluate the student's request, the University requests documentation from an appropriately qualified healthcare provider (DO, MD, NP, PA) who is licensed and **primarily responsible for treating the student for this condition.** The person completing this form cannot be related to the student.

Please answer each question on the form thoroughly, as this information will be used in determining how to address the student's request most appropriately for dietary accommodations. The provision of accommodation is based upon assessment of the **current** impact of the condition(s) on academic performance and access to educational activities.

Student's Name _____

How long have you known the student? _____
Date of your last evaluation _____
What methods were used to evaluate the student? _____

Medical History

Primary Diagnosis and ICD-10: _____
Secondary Diagnosis and ICD-10: _____
(If applicable, attach a copy of test results, i.e. allergy testing, lab work, pathology)
When was this condition diagnosed? _____
How long has the student been under your care? _____
Date of your most recent evaluation related to this condition. _____

Does the student take prescription medication for this condition? YES_____ NO_____
If yes, please specify medications, doses, and frequency:

Does the student utilize other treatments or interventions for this condition? YES____ NO_____

If yes, please describe:

_____
_____
_____
_____

The prognosis for the medical condition or disability above is:

Permanent _____ 6-12 months _____ 6 months or less _____ Episodic (please describe below) _____

_____
_____

Additional Information

Is the impact of the disability life-threatening if the request is not met? YES_____ NO _____

Please explain:

_____
_____
_____
_____

What major life activities are substantially limited by this disability (functional limitations)? Please describe:

_____
_____
_____
_____

How would this dietary accommodation impact the student's function?

_____
_____
_____
_____

What would be the impact if this dietary accommodation cannot be met?

_____
_____
_____
_____

Diet Prescription:

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

   _____
   _____
   _____
   _____

2. Length of time dietary accommodations will be required.

   Ongoing _____Temporary Start Date:_____Temporary End Date: _____

Please Initial One of the Following:

_____ I believe this request for dietary accommodations is medically necessary. I believe that without it one or more major life activities would be substantially limited.

_____ I believe this request for dietary accommodations is a reasonable **preference** but not medically necessary. While it may be beneficial, it will not substantially limit major life activities if it is not granted.

_____ There is insufficient evidence to support the need for this dietary accommodation at this time.

Additional Comments:

Healthcare Provider Name:_____

Please Print

Signature:_____

Type of License: _____

License # / State: _____

Address: _____

Phone: _____ Date: _____

When completed, please fax to 715-425-0742 or send with the student. If you have questions, contact Disability Resource Center professional staff at 715-425-0740, or drc@uwrf.edu.