Return Form
MAIL: Student Accessibility Services
Nazareth College
4245 East Avenue
Rochester, NY 14618
EMAIL: ehess6@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: ___________________

Return Form
MAIL: Student Accessibility Services
Nazareth College
4245 East Avenue
Rochester, NY 14618
EMAIL: ehess6@naz.edu
FAX: 585-389-2499

Food Allergy & Special Nutrition Form

PART II. To be completed by the diagnosing/treating healthcare provider

Client/Patient Name: ______________________________

To assist Nazareth College 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:

ATTN: Special Dining Accommodations Committee
Student Accessibility Services
Nazareth College
4245 East Avenue
Rochester, NY 14618

Email: ehess6@naz.edu
Fax: 585-389-2499