

Addendum: Dietary

Please complete and return the General Provider Form as well

Student name: _____ Date of birth: _____

1. Which diagnoses are related to this dietary request:

2. Describe in detail any significant functional limitations in the environment, including living arrangements, dining hall, class, etc.

3. Has the student previously received dietary accommodations? Yes No
If yes, what accommodations?

4. Please list any specific dietary accommodations that are essential for this student. Include your rationale and how each accommodation would mitigate functional limitations posed by the student's disability.
 Food Allergies Please List:

 Full Meal Plan Exemption Please explain:

 Partial Meal Plan Exemption Please explain:

5. Please share any additional information you believe will be helpful:

6. Does the student's disability or diagnosed condition result in flare-ups? Yes No
 - a. If yes, please describe those flare-ups.
 - b. How often/frequently does the student experience flare-ups? Periodic/Seasonal Monthly Weekly Daily
 - c. How long do flare-ups typically last?
 - d. Describe the level to which the student is able to engage during a flare-up.

7. Please provide provider recommendations:

Provider Name _____ Signature _____ Date: _____

Please return the completed form to SAS via email (sas@wm.edu) or fax (757-221-2538), or return to the student for submission. Thank you for your assistance with this process.