MEDICAL VERIFICATION OF FOOD ALLERGIES OR SPECIAL DIET NEEDS

TO BE COMPLETED BY THE TREATING CLINICIAN

Student Name: ____________________________________ Date: ____________

The student named above has applied for services from the Student Disability Access Center (SDAC) at the University of Virginia. In order to determine eligibility and to provide services, we require documentation of the student’s food allergies or specialized diet plan.

1. Food allergy(ies) and/or medical condition(s). Please list ICD-10 or DSM-5 code(s), as well as the specific food allergens/sensitivities/restrictions which require a special diet.

2. Date of diagnosis: ________________________________

3. Date student was last seen: _______________________

4. Medications, such as an Epipen, or other required medical interventions if student is exposed to allergen:
5. The noted medical condition(s) or allergy(ies) are:
   □ Permanent/□ Long term/□ Short-term/Temporary
   Chronic (6-12 months) (6 months or less)
   Expected duration: __________

6. Level of severity:
   □ Mild/□ Moderate/□ Severe

7. Please use the space below (and additional sheets as needed) to provide any information that would be helpful to SDAC staff in considering the dietary accommodations that you are recommending. You may choose to address these questions:
   a. Is impact of the condition life threatening if the request is not met?
   b. Is there a negative health impact if the request is not met?
   c. What is the likely impact on academic performance if the request is not met?
   d. What is the likely impact on social development if the request is not met?
   e. What is the likely impact on level of comfort if the request is not met?
   f. Is the request an integral component of a treatment plan for the condition in question? If yes, describe the plan for ongoing treatment, including intended treatment providers during the upcoming academic year.
8. Certifying Professional:

Signature ___________________________ Date ________________

Name (Please Print) ________________________________________________

Title ____________________________________________________________

Name of Agency __________________________________________________

Street Address ____________________________________________________

City/State/Zip _____________________________________________________

Phone Number ___________________________ Fax Number ________________

All documentation submitted for consideration to SDAC is confidential. When submitting documentation, please include a copy of any available releases allowing communication between the SDAC and the diagnostician. Documentation should be sent to:

Student Disability Access Center (SDAC)
University of Virginia
P.O. Box 800760
Charlottesville, VA  22908

Phone: 434-243-5180
Fax: 434-243-5188

All recommendations are considered. Decisions are made based on the nature of the disability, reasonableness of the request, and academic integrity.