Accessibility Resources & Services
550 North College Avenue
Claremont, CA 91711
Office: 909.621.8017|Fax: 909.607.7228
Email: Disability@pomona.edu

DIETARY RESTRICTIONS DISABILITY VERIFICATION FORM

TO BE COMPLETED BY TREATING HEALTHCARE PROVIDER: *The student named below is requesting accommodations on the basis of a disability at Pomona College. The information provided here is confidential and will not become part of the patient's educational records.*

SECTION 1: STUDENT INFORMATION

Pomona College has deemed it mandatory for all students to be on a meal plan. Occasionally, students have special needs, which may necessitate accommodations to the meal plan. Exemption from participation in the meal plan is rare and will only be considered when needs cannot be accommodated by Pomona College Dining Services. Please provide as much detail as possible to help us determine appropriate accommodations.

STUDENT NAME: ______________________________ ID:______________ BIRTHDATE (MM/DD/YYYY): _____________

SECTION 2: DIAGNOSTIC INFORMATION

1. DIAGNOSIS: ____ DSM/ICD CODE: ______________________________

ONSET DATE: _______________________________ SEVERITY: ☐MILD ☐MODERATE ☐SEVERE ☐ IN REMISSION

ANTICIPATED DURATION: ☐ CHRONIC/PERMANENT ☐ TEMPORARY; EXPECTED TO LAST: _____________________________

2. DIAGNOSIS: ____ DSM/ICD CODE: _______________________

ONSET DATE: _______________________________ SEVERITY: ☐MILD ☐MODERATE ☐SEVERE ☐ IN REMISSION

ANTICIPATED DURATION: ☐ CHRONIC/PERMANENT ☐ TEMPORARY; EXPECTED TO LAST: _____________________________

SECTION 3: TREATMENT HISTORY

DATE YOU FIRST TREATED THE STUDENT FOR THIS CONDITION: ____

LIST THE DATES YOU HAVE TREATED THIS PATIENT FOR THE PAST 12 MONTHS? ____

IS THERE A HISTORY OF HOSPITALIZATION FOR THIS CONDITION? PROVIDE DATE(S) _______________________________________

CURRENT TREATMENT PLAN/ PRESCRIBED MEDICATION (INCLUDE CURRENT DOSAGE): ___________________________________

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SECTION 4: DISABILITY INFORMATION

PLEASE IDENTIFY THE SYMPTOMS CAUSED BY THE DISABILITY AND HOW THEY SUBSTANTIALLY LIMIT ONE OR MORE MAJOR LIFE ACTIVITIES FOR THE STUDENT:

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PLEASE EXPLAIN HOW THE DISABILITY INTERFERES WITH THE STUDENT PARTICIPATING IN THE COLLEGE'S MEAL PLAN AND/OR EATING IN THE COLLEGE'S DINING FACILITY.

SPECIFY EACH ALLERGEN AND/OR RESTRICTION AND INDICATE THE LEVEL OF SENSITIVITY *(i.e. airborne, contact, cross-contamination, ingestion of food only, other)*	**Life threatening anaphylaxis** (student carries epi-pen).	**High Sensitivity (no anaphylaxis)**
Ex. peanuts	*Cross contamination/ingestion*	

SECTION 5: RECOMMENDED ACCOMMODATIONS

A request for accommodation should be accompanied with a clear rationale for its necessity. Documentation should establish a clear link between the requested accommodation and the functional limitation it seeks to alleviate.

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SECTION 6: PROFESSIONAL CERTIFICATION

By signing below, I am certifying that I am a health care provider who is authorized to practice by the state and performing within the scope of my practice as defined by State laws (29 CFR § 825.125 and AB-468). I also verify that the information is current and accurate to the best of my knowledge based on my recent evaluation of this patient and/or my review of records.

____ ________________________________

PROVIDER'S NAME PROVIDER'S SIGNATURE

____ ________________________________

PROFESSIONAL TITLE, CREDENTIALS, AREA OF SPECIALIZATION LICENSE NUMBER

____

STREET ADDRESS CITY STATE ZIP

(_____)______________________ ____________________________ ______________________

PHONE EMAIL TODAY'S DATE