

Verification Form: Dietary Accommodations

Rev. 01.15.2025

Albright College's Student Accessibility and Advocacy (SAA) office has established verification forms to assist in obtaining current information from a qualified professional (e.g., medical physician, neurologist/neuropsychologist, clinical psychologist, licensed counselor, or other relevant provider) regarding a student's condition and symptoms. This form should be filled out by a licensed professional treating this individual for at least three months. To assist the student, we need to understand the student's symptoms, relevant medications and their impact on the student, and the student's need for accommodations. This verification form may supplement information provided in other reports, including medical reports or secondary school documentation. It is not a replacement for a full evaluation or test scores.

Any documentation must meet Albright College's documentation standards for the student's condition. A summary of the criteria for documenting a disability is listed below. Complete information can be found in the Albright College's Documentation Standards which is provided to the student. If you would like a copy of the standards, please call our office.

- Documentation must show evidence of a disability as defined by the ADA.
- Documentation must be no more than 3 years old except in rare circumstances.
- Documentation must describe functional impairment affecting an important life skill and how this affects the student in the college environment.
- Documentation must provide history relevant to the student's disability, including treatments, assistive devices, or other pertinent information.
- Documentation must establish a clear link between the recommended accommodation and the student's functional limitations.
- Documentation must present a summary and recommendations.

(Please **print legibly** or **type**; illegible documents will not be processed)

PLEASE NOTE: Dietary modifications can be facilitated through Albright College Dining Services where every reasonable effort will be made to support a student’s documented dietary needs while maintaining Albright’s belief that dining with fellow students is an important facet of life at a residential university. Dietary modifications that are currently available through dining services offer a variety of foods that promote healthy lifestyles including gluten-free and lactose-free options, meals for vegetarian and vegan diets, as well as allergy information. In all dining locations across campus nutrition information is either posted or available upon request. To learn more please visit <https://albright.campusdish.com/>

Student Information

Student’s Name: _____ DOB: _____

Home Address: _____

Local Address (if different): _____

Cell Phone: _____ Other Phone: _____

Provider Section

The student named above has requested a dietary-based disability accommodation at Albright College. A disability is defined under the Americans with Disabilities Act as “a physical or mental impairment that substantially limits one or more major life activities.” Examples of major life activities are listed in item 3, below. A temporary impairment may include an injury, severe illness, recovery from surgery, or a condition caused by a traumatic event.

This form is to be completed by a qualified health care provider (who is not related to the student) with experience and expertise regarding the functional limitations of the student’s disability and current symptomology that would impact the student’s housing/dining needs.

Thank you in advance for providing as much detail as possible in your responses. If additional space is needed, please attach additional pages.

Date of initial contact with student: _____

Date of most recent contact with student: _____

(Please **print legibly** or **type**; illegible or incomplete documents will not be processed.)

Diagnosis

What is the student's primary diagnosis? _____ ICD-11: _____

Descriptive features: _____

When was the student diagnosed with THIS condition? _____

What diagnostic tools/tests were initially used to determine this diagnosis? (please submit reports with this form)

When was the most recent diagnostic testing (labs, etc) performed to confirm the current condition?

(Please submit these results and any other pertinent diagnostics with this form)

How long have you been treating the student for THIS condition? _____

How often is the student seen for THIS condition? (e.g., weekly, monthly) _____

Number of consultations with the student for THIS condition over the past 3 years: _____

If care has ended, when did you last see the student for THIS condition? _____

What is the severity of the impairment? Mild Moderate Severe

Please explain how you determined the severity above:

What is the expected duration of the impairment?

Short-term (less than six months)

Episodic

Long-term (six months to one year)

Chronic (more than one year, with frequent recurrences)

Please explain why the above duration was chosen:

(Please **print legibly** or **type**; illegible documents will not be processed)

Current Symptoms

Using as much space as needed, please describe the type, severity, and frequency of symptoms currently experienced by the student, and how the disability interferes with eating or dining in college facilities. Please attach an additional sheet if necessary.

Pharmacology and Side Effects

Is the student taking any prescribed medications for the diagnosis that you are treating or any other medication that may impact the student's ability to eat or dine at college facilities? No Yes

If yes, please provide information below for each medication the student is prescribed.

Medication/Dosage/Frequency: _____

Date first prescribed: _____

Relevant side effects:

Medication/Dosage/Frequency: _____

Date first prescribed: _____

Relevant side effects:

Medication/Dosage/Frequency: _____

Date first prescribed: _____

Relevant side effects:

(Please **print legibly** or **type**; illegible documents will not be processed)

Functional Limitations and Recommended Accommodations

Albright College students residing on campus are required to purchase a meal plan. Please indicate which of the following modifications you are recommending to address this student's dietary needs:

- | | | |
|-------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Beneficial | <input type="checkbox"/> Critical | Access to gluten-free food options |
| <input type="checkbox"/> Beneficial | <input type="checkbox"/> Critical | Access to dairy-free food options |
| <input type="checkbox"/> Beneficial | <input type="checkbox"/> Critical | Access to vegetarian menu options |
| <input type="checkbox"/> Beneficial | <input type="checkbox"/> Critical | Access to vegan menu options |
| <input type="checkbox"/> Beneficial | <input type="checkbox"/> Critical | Specialized diet for gastrointestinal diseases (e.g., Crohn's, colitis, IBS) |
| <input type="checkbox"/> Beneficial | <input type="checkbox"/> Critical | Specialized diet for diabetes |
| <input type="checkbox"/> Beneficial | <input type="checkbox"/> Critical | Menu planning consultation with Dining Services staff |
| <input type="checkbox"/> Beneficial | <input type="checkbox"/> Critical | Menu planning consultation with Albright College's nutritionist |
| <input type="checkbox"/> Beneficial | <input type="checkbox"/> Critical | Other (please specify, with as much detail as possible): |

Please explain the rationale for any selections deemed "critical" and how the recommended modification of the standard meal plan would assuage the limitations posed by the student's underlying condition:

Does the student have any food allergies that need to be addressed by Dining Services staff? No Yes

If yes, what is the student allergic to? _____

- How are allergies triggered? Contact
 Ingestion
 Airborne inhalation

(Please **print legibly** or **type**; illegible documents will not be processed)

Provider's Certifying Information

Professionals rendering assessments and diagnoses and providing recommendations for reasonable accommodations must have experience and expertise related to the student's diagnosis and functional limitations which necessitate dietary accommodations. The provider signing this form must be the same person who answered the questions above and may NOT be related to the student.

Provider's Signature: _____ Date: _____

Provider's Name: _____

Credentials: _____

License Number: _____

State of Licensor: _____

Office or Business Name: _____

Office or Business Address: _____

Office Phone: _____ Fax: _____

Email Address: _____

I have attached reports/results of evaluations that determined the student's pertinent diagnosis.

Directions for Submitting This Form and Supporting Documentation

This form is not a substitute for evaluation or testing data. Please submit this form, along with the student's most current evaluation, test results/scores, and other supporting documents directly to the SAA office. Documentation should be faxed to us at 610-929-6793 or mailed to us at:

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