THE UNIVERSITY of NEW ORLEANS

OFFICE OF STUDENT ACCOUNTABILITY, ADVOCACY AND DISABILITY SERVICES

Medical Documentation Form for Meal Plan Accommodation

To Be Completed By Student's Health Care Professional

University of New Orleans is committed to the full participation of students with disabilities in all aspects of college life, including the dining experience. A major facet of living at a residential college is dining in community. To this end, all students living on campus at are required to purchase a university meal plan. Occasionally, students have special needs based on documented health conditions, such as those resulting in certain dietary restrictions, which may necessitate an accommodation to the Meal Plan.

University of New Orleans (ARAMARK®) Dining Services offers many dining options capable of accommodating different dietary needs, such as gluten free, dairy free, nut free, and foods free of shellfish. Furthermore, the dining hall staff can prepare meals specifically for students with allergies to ensure foods are free of allergens. We encourage students to meet with Dining Service's staff first to inquire about all of the dining options before pursuing a meal plan accommodation.

By signature below, this student has authorized you to provide the University of New Orleans Meal Plan Accommodations Committee with documentation regarding diagnosis and nature/duration of treatment, recommended accommodations/modifications to the meal plan requirement, and any follow-up information we may need regarding this students' meal plan accommodation request.

Student Name (printed): _____ Date: _____

Student Signature: _____

If you as the Medical Professional have any questions regarding the accommodation process, or have additional information to share, **please contact Amy King, Director, Student Accountability, Advocacy and Disability Services, at (504) 280-6222 or aaking@uno.edu.**

***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: seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, thinking, concentrating, learning, reading, communicating, working, performing manual tasks, caring for oneself, and the operation of major bodily functions. A temporary impairment may include an injury, severe illness, recovery from surgery, or a condition caused by a traumatic event.*

Thank you for your responses to the questions below.

1. **Based on this definition, does this individual have a disability?** ☐ **Yes** ☐ **No**
2. **If yes, please cite this student's diagnosed disability or impairment:**

   _____
3. ☐ **The condition is permanent (or)** ☐ **The anticipated duration of the condition is:** _____
4. **Date of Diagnosis:** _____ ☐ **Made by you? If not, by whom?** _____

   Date of most recent evaluation:

   _____
5. **Currently under your care?** ☐ **Yes** ☐ **No** **If no, when did care end?** _____

6. **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.**

7. **Please check any modifications you recommend to the Meal Plan to accommodate the student's medically necessary dietary needs:**

- ○ **Gluten Free**
- ○ **Dairy Free**
- ○ **Vegetarian**
- ○ **Vegan**
- ○ **Kosher**
- ○ **Diet for Gastrointestinal Diseases (e.g., Crohn's)**
- ○ **Diet for Diabetes**
- ○ **Low Glycemic Diet**
- ○ **Other** _____

_____

8. **Explain how this alternative to the standard meal plan would impact the student's underlying condition:**

9. **Any further comments you feel the Meal Plan Accommodation Committee should be aware of?**

10. ☐ **I have attached the documentation with the results of evaluation/testing which led to this diagnosis.**

Health Care Professional's Contact Information
(Stamp, write, or affix business card containing office address, phone number, and email)

Signature _____Date _____

My signature verifies that I am or have been this student's treating health care professional, that the contents are true and accurate, and that I am not a relative of the student.

***NOTE: This form is not to be submitted by the student, but rather to be sent directly to:**

Director, Student Accountability, Advocacy and Disability Services
University of New Orleans
UC 248
2000 Lakeshore Dr.
New Orleans, LA 70148
aaking@uno.edu
Fax: 504-280-3975