Disability Support Services
Lesley University
(617) 349-8655 (via Relay 711)
(617) 649-3704 (fax)
dss@lesley.edu

Food-Related Disability Disclosure Form

For Office Use Only

Date Received:

The licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document **must** complete this form.

INCOMPLETE FORMS WILL DELAY POTENTIAL SERVICES

Student's Name: _____ Date: _____

Clinician's Name: _____

State Licensure/ Certification #: _____

Area of Specialty: _____ Clinician's phone #: _____

Address: _____

The person named on this form is requesting accommodations from Disability Support Services, which offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act Amendments Act (ADAAA) revised in 2008. Under the ADAAA guidelines a person with a disability is one with a physical, mental, emotional or chronic health impairment that ***substantially limits*** one or more major life activity such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

- **I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADAAA disability criteria: Yes☐ No☐**

If yes, please thoroughly complete this form to document the substantial limitations that are linked to this disorder.

1. **Description of Food-Related Disorder or Disability:**

2. The extent of the disorder is: ☐ Mild ☐ Moderate ☐ Severe

3. Onset Date of condition: 4. **Date of last clinical contact**:

4. Expected duration of disorder or disability noted above is:
☐ Permanent/ Chronic
☐ Long term: 3-12 months

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5. What is the frequency and duration of symptoms of the student's condition?

☐ Daily ☐ 1/week ☐ 1-3/week ☐ 1/month ☐ 1-3/year ☐ Seasonal

☐ None – symptoms under control with medication ☐ Other:

6. If these symptoms are related to specific food allergies or intolerances, please indicate these foods (Ex: milk/dairy, eggs, peanuts, tree nuts, fish, shellfish, soy, wheat/gluten, etc.).

7. Assessment Instruments and Results: (Please describe the procedures used to establish the condition):

8. Medications:

Current medications (dosage and side effects):

Long term medication plan:

Current compliance with medical plan:

9. History of hospitalization:

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10. Describe the functional impact of symptoms in the academic setting:

11. Describe the functional impact of symptoms in the residence hall setting:

12. Describe the functional impact of symptoms in the dining hall setting:

13. Suggest potential meal plan accommodations as related to the nature of the condition. Include information about foods to be omitted and appropriate substitutions, contamination, preparation, storage, and seasoning.

14. Additional information:

Clinician Signature: _____Date:_____