WESTMONT

Dietary Disability Documentation

Office of Disability Services (ODS)

Dear Licensed Professional,

Please complete this page and return form to the Office of Disability Services.

Student Name: _____ DOB_____

This portion to be completed by a licensed provider and current within the last year.

Medical Professional's Name: _____

Medical License number _____ State _____

Address _____

Phone: _____ Email: _____ FAX_____

Diagnosis with DSM-V and/or ICD-9 code(s) and date of diagnosis

_____

_____

_____

How long have you been treating this patient? _____

Date last seen _____

What is the nature of the condition?

_____

_____

_____

Will the functional limitation last for the duration of the student's matriculation at Westmont?

- Yes
- No

How does it impact the student? What difficulty or barrier might the student experience related to their condition in a college dining environment?

_____

_____

_____

_____

_____

_____

If the student has a food related allergy, please rate the severity and list specific foods/ingredients to avoid.

- Severe (anaphylactic shock)
- Moderate discomfort (hives, rash)
- Mild but irritating

Avoid the following:

_____

_____

_____

Has the student been prescribed an epi-pen?

- Yes
- No

If the student's condition is due to a medical condition other than an allergy, please describe any dietary restrictions and recommendations.

_____

_____

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_____

All documentation will reside in ODS, but ODS may share medical documentation/diagnosis with the Registered Dietitian/Sodexo Manager, Health Center and others in the Meal Plan Review Committee.

Signature_____Date_____

Please fax to Westmont ODS 805-565-7244 or email to ods@westmont.edu