UT MARTIN

Office of Disability Services

DINING ACCOMMODATION DOCUMENTATION FORM

Federal law requires that students' requests for academic adjustments, auxiliary aids, and other accommodations be determined on a case-by-case basis. This form was created to facilitate the individualized review of each student's request and to assist the Office of Disability Services (ODS) in developing an appropriate accommodation plan together with the student. Information contained herein will be shared with UTM Dining only to the extent necessary to determine appropriate accommodations.

The content submitted to SDS should reflect the most currently available information. This Meal Plan Accommodations Documentation Form should be:

a. Completed by a qualified professional. The diagnosing professional must be a medical specialist with expertise in the area related to the student's disability. The professional may not be related to the student.
b. Completed as clearly and thoroughly as possible. Incomplete responses and illegible handwriting may require additional follow up that could delay the review process.
c. Supplemented with any evaluative reports that may provide a more complete understanding of the student's accommodation needs. Evaluative reports may include comprehensive diagnostic reports such as for allergy testing. Please do not provide case notes or rating scales without a narrative that explains the results.
d. Submitted to Office of Disability Services. All documentation will be held strictly confidential as a student record.

Date: ____________________

Student Name:____Date of Birth:___________________

1. Date of first contact with this individual: __________________________
2. Date of last contact with this individual: ___________________________
3. Diagnoses:
   Primary Diagnosis:____
   Secondary Diagnosis:____
   Tertiary Diagnosis:____

4. Please share the assessments or procedures used to determine the student's diagnoses.

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5. Describe the type, severity, and frequency of symptoms currently experienced by the student and how the disability may interfere with eating in university facilities if not accommodated.

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6. Please provide a detailed narrative about the student's dietary needs, including specific food restrictions necessary due to the medical condition. This information will be used to determine potential accommodations are meal plan considerations.

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7. Describe any currently prescribed medication that may require consideration when determining dietary accommodations needs.

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8. Please share any additional information you feel will be useful in evaluating the student's disability and provide recommendations to be considered in determining appropriate accommodations.

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HEALTHCARE PROVIDER INFORMATION

By signing this form, the healthcare professional certifies that they are an appropriately credentialed or licensed professional trained in the assessment and treatment of the diagnosis (es) described herein.

Provider Name (Print):____

Provider Signature:____

License or Certification #:____

Address:____

Phone:____________________ FAX:____________________

PLEASE EMAIL, MAIL, OR FAX INFORMATION TO:

206-209 Clement Hall
DisabilityServices@utm.edu
731.881.7195
Fax: 731.881.7702

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