



## **Request for Dietary Accommodation**

### **What is the Policy and Process?**

Saint Mary's University provides reasonable accommodations to students with disabilities. The Office of Student Affairs is responsible for meal plans and dietary accommodation requests. Students requiring dietary accommodations should complete the Request for Dietary Accommodation paperwork. Once documentation has been received by Student Affairs, a meeting with the Registered Dietician will be set to discuss the request.

Dietary accommodations vary according to the individual needs of each student and will be determined on a case by case basis. Every effort will be made by food services to accommodate the student's needs. This process typically requires multiple visits with the Dietitian, working collaboratively develop a plan tailored to the individual student.

These meetings may cover information including but not limited to:

- Review of the impact of the medical condition
- Evaluation of the student's current food service utilization
- Assessment of the student's nutritional knowledge as it relates to the condition
- Assessment of the student's knowledge regarding dietary options and services available on campus.
- Review of the student's current living situation as relates to assets/deficits in nutrition.

Dietary accommodations are granted for one academic year. Students who have been granted a modified meal plan or an exemption to the residential meal plan requirement are responsible for scheduling a meeting with the Student Affairs yearly to re-evaluate the adequacy of the plan and resubmit the necessary documentation. Renewal is not guaranteed.

The student has the right to decline the recommendations and/or appointments, however, in doing so, the student waives the right for further consideration of their request for dietary accommodations.

Documentation or questions should be submitted to:

Student Affairs – Griffin Hall 195  
Phone: 507-457-1640  
Fax: 507-457-8708  
Email: [studentaffairs@smumn.edu](mailto:studentaffairs@smumn.edu)

**Students without a Diagnosed Disability:**

The Campus Registered Dietitian is available to all students for consultation for both medical and non-medical concerns. Any student with dietary concerns is encouraged to schedule an appointment (at no cost).

Staci Gallahue, Registered Dietitian

Phone: 715-425-3863

Email: [Staci.Gallahue@compass-usa.com](mailto:Staci.Gallahue@compass-usa.com)

|                                       |
|---------------------------------------|
| <b>To Be Completed by the Student</b> |
|---------------------------------------|

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Current Campus Housing: \_\_\_\_\_

What is your food allergy or medical diagnosis?

What is the impact or limitation associated with this allergy or medical condition?

What accommodations are you requesting? Please explain how this accommodation will address the limitations described above.

**Release of Information\*:**

- ☐ I authorize Saint Mary's University and its representatives to share information related to my *Request for Dietary Accommodations* with relevant departments and individuals. I recognize that the sharing of this information is necessary for departments to work collaboratively for my benefit.
- ☐ I authorize Saint Mary's University and its representatives to contact my healthcare provider for additional information, related to this request.
- ☐ I recognize that submission of the *Request for Dietary Accommodation* and accompanying documents does not guarantee a specific request will be granted.
- ☐ I have read this document thoroughly and agree to the process described.

\*This release is effective for 1 year from the date of signature.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

|   |
|---|
| <b>To Be Completed by the Healthcare Provider</b> |
|---|

**Instructions for Students:**

Please complete the *Consent for Release of Information* below and deliver this form to the healthcare provider who is **primarily responsible for treating you for this condition**.

**Consent for Release of Information (to be completed by student):**

I authorize \_\_\_\_\_ (healthcare provider's name) to disclose the information requested on this form to Saint Mary's University for the purpose of evaluating my request for housing accommodations. I authorize both parties to discuss information, as needed, related to my request.

\*This release is effective for 1 year from the date signed.

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Instructions for Healthcare Provider Completing this Form:**

The student named above has requested a dietary accommodation at Saint Mary's University. All students living on campus are required to have a meal plan, unless otherwise granted permission by the Office of Student Life.

Saint Mary's University provides reasonable accommodations to students with documented disabilities. Dietary accommodations vary according to the individual needs of each student and will be determined on a case by case basis. In order to effectively evaluate the student's request, the University requests documentation from an appropriately qualified healthcare provider (DO, MD, NP, PA) who is licensed and **primarily responsible for treating the student for this condition**. The person completing this form cannot be related to the student.

Please answer each question on the form thoroughly, as this information will be used in determining how to most appropriately address the student's request for dietary accommodations.

Please feel free to contact us with any questions you may have: (507) 457-1640.

**Completed forms and supporting information can be returned with the student or faxed to:**

Saint Mary's University – Student Affairs  
Fax: 507-457-8708

## Healthcare Provider Statement for Dietary Accommodations

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### Major Life Function/Disability Information

Accommodations are only available to students identified as having a disability or severe medical condition. 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 include: seeing, hearing, eating, sleeping, walking, standing, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and self-care.

Based on the above definition, does the individual have a disability? **YES NO**

### Medical History

Primary Diagnosis and ICD-10: \_\_\_\_\_

Secondary Diagnosis and ICD-10: \_\_\_\_\_

(If applicable, attach a copy of test results, i.e. allergy testing, lab work, pathology)

When was this condition diagnosed? \_\_\_\_\_

How long has the student been under your care? \_\_\_\_\_

Date of your most recent evaluation related to this condition? \_\_\_\_\_

Does the student take prescription medication for this condition? **YES NO**

If yes, please specify medications, doses and frequency:

Does the student utilize other treatments or interventions for this condition? **YES NO**

If yes, please describe:

The prognosis for the medical condition or disability above is:

Permanent \_\_\_\_\_ 6-12 months \_\_\_\_\_ 6 months or less \_\_\_\_\_ Episodic (please describe below) \_\_\_\_\_

### **Additional Information**

Is the impact of the disability life-threatening if the request is not met?      **YES**    **NO**

Please explain:

What major life activities are substantially limited by this disability (functional limitations)? Please describe:

How would this dietary accommodation impact the students function?

What would be the impact if this dietary accommodation cannot be met?

Given the functional limitations of the student's condition, what dietary accommodations are medically necessary?

### **Please Initial One of the Following:**

\_\_\_\_\_ I believe this request for dietary accommodations is medically necessary. I believe that without it one or more major life activities would be substantially limited.

\_\_\_\_\_ I believe this request for dietary accommodations is a reasonable **preference** but not medically necessary. While it may be beneficial, it will not substantially limit major life activities if it is not granted.

\_\_\_\_\_ There is insufficient evidence to support the need for this dietary accommodation at this time.

**Additional Comments:**

Healthcare Provider Name: \_\_\_\_\_ DO, MD, NP, PA  
Please Print Circle One

Signature: \_\_\_\_\_

License # / State: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Medical Office Stamp:**

**Completed forms and supporting information can be returned with the student or faxed to:**

Saint Mary's University – Student Affairs  
Fax: 507-457-8708

**PLEASE DO NOT WRITE BELOW THIS LINE**

☐ Approved ☐ Denied ☐ Additional Information Needed

Notes: