Office of Health Services
MacClosky Townhouse Commons
515 Loudon Road
Loudonville, NY 12211
Telephone# 518-783-2554
Fax# 518-783-2961

MEAL PLAN MODIFICATION REQUEST DUE TO A DISABILITY

Name		
Date of Birth	SID #	Cell Phone Number

This Meal Plan Modification Request Form is to be thoroughly completed and returned to Health Services. Incomplete forms will not be reviewed.

This Form is to Be Completed by a Licensed Physician or Medical Specialist:

Please respond to the following questions regarding the student named above:

1. Please indicate when you first started seeing the above-named patient for the impairment/condition described in this form:

_____
_____
_____

2. As per the American with Disabilities Act, Please indicate whether the student has a physical or mental impairment that substantially limits a major life activity, and if so, what the condition is, what major life activity is substantially limited by it, and how the major life activity is substantially limited by the impairment:

_____
_____
_____

3. How long has the student had this condition?

_____
_____
_____

4. Describe elements of the student's current treatment plan (including any medications or special diet) that would implicate issues related to the College's meal plan:

_____
_____
_____

5. What is the severity of the condition?

_____
_____
_____

6. Based on the student's current medical condition, please indicate specific dietary requirements you recommend, if any:

_____
_____
_____

7. Describe the symptoms related to the student's condition, if any, that cause significant impairment in one or more major life activities and which would support the student's request for the accommodation being requested:

_____
_____
_____

8. Please provide comment as to how the special dietary requirement requested will meet the student's needs based on the disabling condition:

_____
_____
_____

9. In your opinion, how important is it for the student's well being to have the accommodation being requested? (1 = not important, 5 = critically important). _____

10. Please explain the rationale for your response to the previous question:

_____
_____
_____
_____
_____
_____

11. What consequences, in terms of impairment-related symptomology, would in your opinion result if the College does not approve the requested accommodation?

_____
_____
_____
_____
_____
_____

The provider may also send a report that provides additional related information. The provider completing this form cannot be related to the student and must practice in the specialty area related to the condition identified.

Signature of Provider:_____Date: _____

Address: _____

City:_____State:_____ ***Affix Office Stamp Below***

Telephone #: _____

Fax #: _____

OFFICE USE ONLY

Request Reviewed: Date _____ Approved_____Referred to Nutritionist: _____and/or Accessibility Services_____

By_____

Student Notified: Date_____ By: E-Mail_____Letter_____

Community Living Notified: Date_____ By: E-Mail_____Letter_____

Dining Services Notified: Date_____ By: E-Mail_____Letter_____

Accessibility Services Notified by:_____