

Process Overview

The Dining Accommodation Request Form is intended for students who are requesting reasonable accommodation due to disability or diagnosed medical/psychological condition. Information provided on this form is protected by FERPA and therefore is shared on a need-to-know basis only.

Note: All reasonable attempts will be made to accommodate a student's medical condition through the University's existing dining plans. Students requesting reasonable accommodation are required to make a good faith effort to engage in an interactive process with the Office of Accessibility Services, Dining Services, and Residence Life regarding their dining experience and the related medical condition. In the rare occurrence that Dining Services is unable to provide a reasonable accommodation for a medical condition, the University will consider a reduction in a student's dining plan. A reduction in a dining plan may require the student to use a common kitchen in a residence hall and may require a change in room assignment.

Submitted forms are reviewed by the Office of Accessibility Services, which may seek input from Residence Life and Dining Services to identify ways in which the University can reasonably accommodate a student. Requests are reviewed based on a number of factors, including but not limited to, the severity of the student's disabling condition, the severity of impacted major life functions, medical necessity of an accommodation, and the University's ability to provide a reasonable accommodation.

After reviewing accommodation requests, the Office of Accessibility Services will contact the student to provide additional instructions, which may require a follow-up meeting between the student and Dining Services to determine how to safely accommodate a student's medical need.

All communication will be sent to the student's Clarkson email. The University will communicate directly with the student requesting the accommodation and, as needed, the provider. The office does not communicate with other students, family, or friends of the student requesting the accommodation. If a student needs assistance understanding the reasonable accommodation process, they may request an individual to be present during any meetings or phone calls, but all communication is directly between the Office of Accessibility Services and the student making the request.

Completing the Dining Accommodation Request Form

Section 1: Completed by the student requesting medical accommodation. The student shows this completed portion to their provider when requesting they complete Section 2.

Section 2: Completed by a licensed diagnostician or qualified clinician (e.g. primary physician, nurse practitioner, physician's assistant, licensed mental health professional, etc.). The diagnostician must have an established patient relationship with the student, have provided treatment for the condition, and be an impartial individual who is not a family member of the student.

Submitting completed forms: The student shall submit both Section 1 and Section 2 through the OAS Intake Form on myCU. Questions about how to access the intake form should be addressed to oas@clarkson.edu or 315-268-7643.

Deadlines

Forms may be submitted at any time during any semester.

For any requests associated with an adjusted dining plan, forms must be submitted by the end of the second week of the semester for any requests associated with an adjusted dining plan. Forms submitted after this deadline will be considered, but any approved dining plan changes will not occur until the following semester.

Section 1: Completed by Student

First and Last Name: _____

Student ID: _____

Email: _____@clarkson.edu

Graduation Year: 20_____

Semester to begin reasonable accommodation, if approved: ☐ Fall 20_____ ☐ Spring 20_____Type of request: ☐ Temporary condition ☐ Ongoing or permanent condition

Briefly describe the disabling condition/diagnosis for which you are requesting reasonable accommodation.

My related condition is: ☐ Airborne and consumption based ☐ Consumption based only

What specific foods or types of foods are impacted by the related condition?

What major life functions are substantially limited by the related condition in your daily life?

How are these major life functions impacted if you are exposed to the foods you listed above?

Please select the requested reasonable accommodation(s). *Note: This does not indicate approval or availability.*

- | | |
|--|---|
| ☐ Allergen-free ingredients | ☐ Meeting with Dining Services staff |
| ☐ Emergency procedures review | ☐ Separate meal preparation and dining areas |
| ☐ Individually prepared meals | |
| ☐ Other: _____ | |

I understand that once this form is submitted, the form and relevant medical documentation included in my request will be reviewed by the Office of Accessibility Services, Dining Services, and Residence Life. I understand that this information will be used in evaluating my request and if applicable, planning for my accommodation. The statements and documentation in my application are accurate as I know them. I understand that intentionally providing false information would constitute a violation of the Code of Student Conduct and will result in disciplinary action.

Student Signature_____
Date

Section 2: Completed by Licensed Diagnostician or Clinician

The student is applying for a reasonable accommodation at Clarkson University due to a disability and/or diagnosed medical/psychological condition. In order for the University to establish whether this student qualifies for such accommodation, we need your assessment and diagnosis of the student in addition to their completion of Section 1.

This form must be completed by an appropriate licensed diagnostician or qualified clinician (e.g. primary physician, nurse practitioner, physician's assistant, licensed mental health professional, etc.). The diagnostician must have an established patient relationship, have provided treatment for the condition, and be an impartial individual who is not a family member. This completed form can be returned to the student or sent directly to our office via email at oas@clarkson.edu or fax ATTN: OAS at (315)268-6643.

Patient/Student Name: _____ Date: _____

Current diagnosis and date of original diagnosis: _____

The related condition is: ☐ Airborne and consumption based ☐ Consumption based only

What specific foods or types of foods are impacted by the related condition?

Describe (or attach) a detailed treatment management plan, including a list of daily medications. _____

Complete the following chart. Major life functions may include but are not limited to breathing, caring for self, communicating with others, eating, hearing, learning, lifting, reaching, reading, seeing, sitting, sleeping, talking, thinking, walking, and writing. Include an attachment if necessary.

Indicate each major life function that is substantially limited.	How does the condition substantially limit the major life function in a dining setting?	Is functional limitation life threatening?

Provide your professional opinion on the medical necessity of the following accommodations based on the student's condition. If identified as medically necessary, provide supporting information for the University's consideration. Note this does not guarantee approval or availability. Include an attachment if necessary.

Dining Accommodation	Assessment of Medical Necessity	Describe the Symptom(s) Associated with the Student's Condition which Necessitate this Accommodation
☐ Allergen-free ingredients	☐ Medically necessary ☐ Convenient, not medically necessary	
☐ Emergency procedures review	☐ Medically necessary ☐ Convenient, not medically necessary	
☐ Individually prepared meals	☐ Medically necessary ☐ Convenient, not medically necessary	
☐ Meeting with Dining Services staff	☐ Medically necessary ☐ Convenient, not medically necessary	
☐ Separate meal preparation and dining areas	☐ Medically necessary ☐ Convenient, not medically necessary	
☐ Other (please specify):	☐ Medically necessary ☐ Convenient, not medically necessary	

Students are required to participate in dining plan as a residential student. The University is able to accommodate almost all medical needs through allergen-free cooking areas, individually prepared meals, or other creative avenues. The student is expected to make a good faith effort with Dining Services to meet their medical needs. Only in the event Dining Services is unable to safely accommodate a student's medical needs will the University consider removing a student from the dining plan. **If you believe that is the situation for this student, please describe the functional limitations that cannot be met through campus dining and detail the specific needs for the student's condition.** The University will review the request and determine what accommodations can be provided to the student. Include attachment if necessary.

By completing this form, I attest that the patient/student's aforementioned one or more conditions rise to the level of a disability under ADA/504 and require reasonable accommodation. I also attest that I have reviewed Section 1 (completed by the patient/student) and completed Section 2 accurately and to the best of my ability.

Printed Name and Title	Signature	Date
Certification or License #	Phone #	Fax #
Clinic Name	Street Address	City, State, ZIP Code