



THE UNIVERSITY OF
TENNESSEE
KNOXVILLE

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 Student Disability Services (SDS) in developing an appropriate accommodation plan together with the student. **Information contained herein will be shared with Vol 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 Student Disability Services.** All documentation will be held strictly confidential as a student record.

Student Disability Services
1534 White Avenue/199 Blount Hall, Knoxville, TN 37996-3107
865-974-6087 (p) 865-974-9552 (f) 865-622-6566 (vrs)
sds.utk.edu

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Flagship Campus of the University of Tennessee System 

Date: _____

Student Name: _____ Date of Birth: _____

1. Date of first contact with this individual: _____

Date of last contact with this individual: _____

2. Diagnoses:

Primary Diagnosis: _____

Secondary Diagnosis: _____

Tertiary Diagnosis: _____

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

4. 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.

5. 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.

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

7. 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.

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: _____