

Elon Dining Accommodations Provider Form



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By completing the following form, you affirm that you are a **licensed provider** who is qualified to diagnose, manage, or treat the diagnosis or condition of the named student. This form is **not** to be completed by the student or a family member, including a family member who is a licensed provider.

Once completed, please return to the Office of Disabilities Resources via email (disabilities@elon.edu) or secure fax (336-278-6514). Thank you!

Student Information

Student Name:

Student Date of Birth:

Student ID (if known):

Provider Information

Name of Provider:

Provider Credentials:

Provider Phone Number:

Provider Email (if available):

Explanation of Need for Dining Accommodation

1. What is/are the student's diagnosis(es)?
2. Which major life activity(ies) or bodily function(s) does the diagnosis impact? (e.g., digestion, immune response, endocrine system, cognitive function, etc.)

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3. What is the severity and type of impact on the student? (e.g., anaphylactic response, hives, sensory difficulties, gastrointestinal upset, etc.)

4. What procedures or tests were used to determine the diagnosis? (e.g., blood serum testing, allergen panel, colonoscopy, psychological evaluation, etc.)

5. If a specific diet is recommended, please include specifics about that diet or restrictions that the student must follow per your professional expertise.

6. If you have specific recommendations for adjustments to dining at Elon for the student, please include those below. This can include recommendations for special meals, adjustments to the meal plan, or something else.

Professional Verification and Signature

Choose one:

I am attaching my business card as verification of my completion of this form.

I am attaching a brief statement **on my official letterhead** of the last appointment I had with the named student. I am including my address, phone number, professional credentials, and signature.

Provider Signature:

Date:

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