



Salve Regina University

Dietary Accommodation Request Form

Medical Documentation

Part 1: *To be completed by student*

AUTHORIZATION FOR RELEASE OF INFORMATION

I am requesting the release of medical information regarding my disability by _____ (health care provider named below) to Disability Services and Sodexo Dining Services at Salve Regina University.

Student Signature _____ Date _____
Student DOB _____

Part 2: *To be completed by health care provider addressing above named student*

Health Care Provider Name: _____

MD Nurse Registered Dietitian Mental Health Provider

Specialty: _____

Office Phone Number: _____

Date of initial appointment with student: _____

Date of most recent appointment with student: _____

Medical Diagnosis/Conditions

Medical Diagnosis: _____

Food Allergy to: _____

Brief explanation of how Sodexo Dining services at Salve Regina University can assist with student's special dietary needs: _____



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Length of time special diet must be followed: _____

Other important notes: _____

I certify that the above named student requires special dietary modifications as described above due to the student's food allergies and/or medical conditions.

Health Care Provider Signature: _____

Date: _____

Please return completed and signed form to Salve Regina Disability Services via
Fax or Email

Fax: (401)-341-2912

Scanned and Emailed : disabilityservices@salve.edu