Disability Services
disabilityservices@byuh.edu
808-675-3518

REQUEST FOR REASONABLE FOOD ACCOMMODATION FOR SEVERE FOOD ALLERGIES

BYU–Hawaii supports a climate of equal opportunity in its programs, activities, and services according to applicable law, including providing food accommodations for students with disabilities. As part of the process for requesting food accommodation, current information needs to be obtained from a licensed medical practitioner who is the primary treating professional regarding a student's allergies and dietary restrictions and its impact on the student and their need for food accommodations. This Verification Form may supplement information that is provided in other reports, including medical reports, assessments, or secondary school documentation. Any documentation, including this Verification Form, must meet BYUH DS guidelines for severe food allergies.

** **Food Allergens Disclaimer:** BYUH Dining provides consumers with allergies or dietary restrictions a selection of items with **no milk, soy, eggs, peanuts, tree nuts, shellfish, fish or wheat ingredients (Gluten Free) at a Food Allergen and Dietary Counter** in the Club dining facility. Foods prepared in BYU–H facility may come in contact with these allergens inadvertently. Our staff strives to prevent cross-contact of these items during preparation. Therefore, it is ultimately the responsibility of the customer to judge whether or not to consume the selected foods.

This form is a request for special accommodation that cannot otherwise be met by the Food Allergens and Special Diet Counter:

A request for reasonable food accommodation may be submitted at any time, but for best consideration, please submit all your paperwork before the following deadlines:

Deadlines:

Fall	**August 1**
Winter	**December 1**
Spring	**March 1**

This form will be reviewed by the Disability Services Coordinator (DSC) who will verify the disability as to the reliability of the request. The DSC will then notify the student if they are eligible for accommodations.

I. Student Information: (Please Print Legibly or Type)

BYUH ID #:

Student's Name

First:

Middle:

Sur/Last:

Date of Birth:

Student's Current Address:

Street:

City: State: Zip:

Phone:

Email:

II. TO BE COMPLETED BY HEALTHCARE PROVIDER

To properly evaluate how BYU–H can best meet the student's need for reasonable food accommodations, we require diagnostic information from a licensed professional or healthcare provider that is familiar with the history of the student's food allergens.

1. State the specific food accommodation(s) that you believe this student requires:

2. Describe how the student's severe allergies necessitates/warrants this accommodation request:

3. When was the last attended appointment with you? _____

4. How long have you directly treated this student for his/her condition(s)? _____

5. How long is the student's severe allergies likely to persist?

Limitations Caused by the Allergy:

Does the requester's allergy substantially impact a major life activity (e.g., seeing, hearing, eating, sleeping, walking, self-care, etc.) or bodily function (e.g., digestion, respiratory, circulatory, etc.)?

□ **No**— (please explain):

_____

_____

□ **Yes**—Please complete the information below.

_____

_____

III. Provider's Certifying Professional Information:

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., licensed physician, psychiatrist, clinical psychologist, or neuropsychologist). The provider signing this form must be the same person answering the above questions.

***Note**: For ethical reasons, documentation from a family member or relative cannot be accepted, even if they are licensed.

Provider's Name: (International Providers, please fill out as much information as possible about your qualifications)

First:

Middle:

Last:

Credentials

License Number*:

State of Licensure:

Street Address:

City:

State:

Zip:

Phone #:

Email Address:

Stamp Here (unless provider is from BYUH):

Signature of Provider: Date:

☐ ***I authorize BYU–Hawaii to receive information from the healthcare provider above. I also authorize my healthcare provider to discuss relevant information as to my condition(s) with the appropriate and qualified BYU–Hawaii personnel on an as-needed basis.***

Signature of Student: Date:

Submitting this Form:

This form may be returned to the student or submitted directly to the Disability Services Office at BYU–Hawaii. Information regarding BYU–Hawaii's Disability Services Office can be found at: https://disability.byuh.edu/. If you have any additional questions, you may contact disabilityservices@byuh.edu or 808-675-3518. Thank you for assisting BYU–Hawaii in this accommodation process.