Practitioner Verification for Dining Accommodations

Dear Student,

Please sign the consent for release statement below, and deliver this form to your provider. Call our office at 320-363-5245 if you have questions or concerns.

Consent for Release of Information (to be completed by student):

I authorize_____(physician or evaluator's name) to disclose the information requested by this form to CSB/SJU Student Accessibility Services, for the purpose of evaluating my request for dining and/or residential accommodations. I also allow both parties to discuss any information related to my housing accommodation request.

Student name (print)_____ Date of Birth:_____

Banner ID Number: _____

Student Signature:_____ Date:_____

Attention provider completing this form:

The student named above has requested a dining accommodation at The College of St. Benedict & Saint John's University (CSB/SJU). As Benedictine residential liberal arts colleges, CSB/SJU promotes the development of the individual within the context of living and learning in community. As such, all students enrolled at CSB/SJU are required to live on campus and have an active meal plan, unless otherwise granted permission by the Office of Residential Life and Housing.

CSB/SJU provides reasonable accommodations to students with documented disabilities. In order to accurately and equitably evaluate each request, CSB/SJU requires documentation from an appropriately qualified practitioner that is currently treating the student. The practitioner should have an active professional license in Minnesota or the state in which the student primarily resides. The qualified practitioner completing this form cannot be related to the student.

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Student's Name: _____ DOB: _____

Please thoroughly answer each question on the form, as this information will be utilized to make a determination of accommodation eligibility.

Diagnostic Information

Accommodations are only available to students identified as having a disability or severe medical condition. A disability is defined under the Americans with Disabilities Act as **"a physical or mental impairment that substantially limits one or more major life activities."**

Examples of major life activities: major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

Based on this definition, does the individual have a disability?_____yes _____no

State the student's primary diagnosis and secondary diagnosis/es with corresponding ICD-10 codes:
(If applicable, attach a copy of test results, e.g. allergy testing, blood tests, pulmonary functioning)

_____

_____

Did you diagnose this individual with the above mentioned condition(s)?_____yes _____no

Date of Diagnosis:_____ Date of your most recent evaluation: _____

When did you first meet with the student regarding this diagnosis? _____

Is the student currently under your care?_____yes _____no

Are you related to the student? _____yes _____no

The prognosis for the medical condition or disability above is:

- ☐ Permanent/Chronic
- ☐ Long-term: 6-12 months
- ☐ Short-term/Temporary: 6 months or less
- ☐ Episodic (please describe below) Expected duration: _____

What is the severity of the condition? Please mark one:

☐ Mild ☐ Moderate ☐ Severe ☐ In remission

Does the student take prescription medication for this condition?

- ☐ Yes, specific medications, doses and frequency: _____
- ☐ No

Major Life Functions Assessment: Please check each of the following major life functions that are impacted by the disability. Indicate the degree of limitation**:**

Life Activity	Limitation on Function	Degree of Limitation
☐ Eating		Negligible moderate substantial
☐ Breathing		Negligible moderate substantial
☐ Operations of a major bodily function		Negligible moderate substantial
☐ Other:		Negligible moderate substantial

Given the functional limitations of the student's condition, what accommodations and/or considerations are medically necessary?

Briefly describe the rational for the recommended accommodations**:**

Is this accommodation an essential component of an active treatment plan for their documented disability?

Is the impact of the disability life-threatening if the request is not met? Please explain:

_____

_____

_____

Provide a list of environmental factors that might exacerbate this condition:

_____

_____

_____

For Allergies:

Patient is allergic to (Please check all that apply):

Dairy _____ Egg _____ Fish_____ Peanuts_____

Shellfish_____ Soy_____ Tree Nuts_____ Wheat/Gluten _____

Other (please specify): _____

If the diagnosis a food allergy, describe the reaction/potential if exposed to the allergen:

_____

_____

_____

_____

Diet Prescription: Please provide a list of food items that must be omitted from your patient's diet and a list of safe and appropriate substitutions:

OMITTED FOOD	SUBSTITUTION (if applicable)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

All recommendations are considered. Potentially effective and equivalent alternatives may be identified as needed. Decisions are made based on the nature (severity) of the disability and functional limitations, reasonableness of the request, availability of resources and the timeliness of the request.

Treating Clinician Name (please print)_____ Date _____

Treating Clinician Signature: _____

Professional Title _____

Issuing State/License Number: _____

Address:_____

City, State, Zip: _____

Telephone_____

Fax:_____ Email: _____

Please return this form, along with any supporting documentation to:

CSB/SJU Student Accessibility Services
CSB HAB 105
37 S College Ave
St. Joseph MN 56374
Phone: 320-363-5245
Or fax to: 888-636-1355