

MONTCLAIR STATE UNIVERSITY

DINING ACCOMMODATIONS REQUEST FORM

Montclair State University is committed to full inclusion of students with disabilities into every aspect of university life. Participating in the residential dining program is one of the fundamental aspects of community development in a living/learning environment. Students living in traditional housing at Montclair State University must sign up for a meal plan. It is a part of your housing license. Students with food allergies or other conditions that limit what they can and cannot eat will be accommodated to the fullest extent possible in our dining halls.

Waiver of university meal plans are very rare, and only will be considered on a case by case basis if Dining Services cannot provide the student with alternative meals which would be both nutritious and safe. All students must request accommodations first. If Dining Services feels no accommodation is possible, only then would a meal plan waiver or reduction be considered. Accommodations that can be provided by a change of housing assignment for eligible students will be offered as the first option pending availability.

Please note that this policy only applies to students whose food allergies or medical condition are diagnosed and documented. This policy does not apply to students with specific food preferences based on lifestyle choices, ex. vegans or vegetarians. A variety of options are available in the dining halls for those who choose to eliminate certain foods from their diet.

In order to request dining accommodations, the student must:

- Complete Form 1
- Have a clinician complete Form 2. This form must be submitted by an appropriate medical professional who is not related to the student.
- Register with the Disability Resource Center and work jointly with the DRC and Dining Services to arrange appropriate dietary accommodations. A food modification plan will be completed and implemented based upon the recommendation of your medical provider.
- Submit all documentation to the Disability Resource Center in Cole Hall 331. Forms may be faxed to 973-655-5308 or emailed to drc@mail.montclair.edu.

All requests will be considered by representatives from Dining Services and The Disability Resource Center. Please allow 10 business days before a final decision is reached. You will be notified via email regarding how to proceed with your accommodated meal program.

Students seeking to appeal the decision must do so in writing to Associate Dean of Students, Yolanda Alvarez within two business days of receiving the decision. Dean Alvarez is the University's Section 504 Compliance Officer. Requests for appeals will only be considered if there is new information that was not considered or if the procedures for the review of your request were not followed.

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Medical Statement for Students Requesting Dietary Accommodations for Medical Reasons

Student Name _____

Campus Address _____

Email address _____

Name of doctor _____

Diagnosis _____

Release of Information and Statement of Understanding

Please review the following and provide your initials on the lines below:

_____ I have read and understand the Montclair State University procedures for requesting dining accommodations, and I agree to the terms and conditions.

_____ I understand that incomplete forms will not be considered. A completed request consists of:

Request form and statement of understanding completed and signed by the student

A completed and signed form submitted by a medical practitioner

_____ I understand that my personal medical information will be shared on a “need to know” basis with other university offices.

_____ I have the right to inspect and receive copies of my personal medical documentation.

_____ My signature indicates that all information I provide and submit is true and accurate. I acknowledge that providing false information will result in denial of my request. Providing fraudulent documentation is a violation of the Student Code of Conduct and may result in disciplinary action.

By my signature below, I give my consent to the Disability Resource Center to contact my medical provider if additional information is needed. Any such discussion will focus on the disability disclosed on this form only.

Student Signature _____

Date _____

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FORM 2 - MEDICAL REQUEST FOR DIETARY ACCOMMODATIONS

To be completed by treating medical practitioner

Your patient is seeking dining accommodations due to a medical condition. Students seeking dining accommodations must have a diagnosis that makes these dietary modifications medically necessary. No accommodations will be made regarding food preferences.

Student Name _____

Diagnosis (please include code) _____

Date of diagnosis _____

Date of most current evaluation _____

For Allergies:

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

Dairy _____

Egg _____

Fish _____

Shellfish _____

Soy _____

Peanuts _____

Tree Nuts _____

Wheat/Gluten _____

Other (please specify) _____

If there is another medical condition that requires dietary accommodations, please specify here:

DIETARY 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. Feel free to use additional space, as needed.

OMITTED FOOD/INGREDIENTS	SENSITIVITY LEVEL (Ingestion/Physical Contact/Other)	SUBSTITUTION (When Applicable)

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I certify that the above named patient needs special dietary accommodations as described above due to a diagnosed food allergy or medical condition. My signature verifies that I am currently treating this patient, and that the above information is true and accurate.

Name _____

Address _____

License # _____

Specialty _____

Signature _____