FAIRLEIGH DICKINSON UNIVERSITY

Meal Plan Modification Request Form

(Medical)

To properly evaluate how Fairleigh Dickinson University can best meet your needs regarding University meal plans, the University requires sufficient information to understand how the requested modification relates to the current impact of the disability/medical need.
Please understand that submission of this form does not guarantees the specific modification requested will be granted. Factors we consider when evaluating meal plan modification requests are the severity of the disability/medical need, efficacy of the request, timing of the request and the feasibility and availability of the requested modification.

Directions to Student:

1. Complete Part I
2. Sign the Consent for Release of Information in Part II
3. Provide Part II to your disability evaluator or physician
4. Both parts must be returned to the Office of Disability Support Services by **August 1st for Fall semester and January 2nd for Spring semester. (See contact information at the end of this form)**
5. All meal plan modification decisions are rendered by the first day of classes.

Part I: Student to complete the following:

Name (please print clearly): _____

Address: _____

FDU ID#: _____ FDU Email: _____

Cell Phone #: _____ Home Phone #: _____

Status: Incoming First-Year Student Transfer Student Returning Student

Campus: Florham Campus Metropolitan Campus Wroxton Campus

Modification Request is for: ☐ Fall ☐ Spring 20_____

1. State the disability/medical condition for which you are requesting a meal plan modification:

2. Have you had this modification at Fairleigh Dickinson University in the past? YES NO

If yes, what semester: Fall 20 _____ Spring 20_____

3. Please select the meal plan modification(s) you are requesting:

- ❑ **Meal Plan D** (8 meals per week and $200 Flex)
- ❑ **No Meal Plan**
- ❑ **Other (please explain)**_____

4. Please describe how this modification will address your disability/medical need?

5. Please add any other information you feel is important for us to consider in reviewing your request:

Student Signature: _____ **Date:** _____

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Part II: Physician or Disability Evaluator Verification

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

I authorize _____ (physician or evaluator's name) to disclose the information requested by Fairleigh Dickinson University that is reasonably necessary to evaluate my request for the above requested meal plan modification. I also authorize Fairleigh Dickinson University and my physician/evaluator to discuss any information related to my meal plan modification request. I understand that my personal medical information may be shared on a "need to know basis" with other University offices.

Student Name: _____ FDU ID #: _____

Student/Guardian Signature: _____ Date: _____

PROFESSIONAL EVALUATION OF DISABILITY/MEDICAL CONDITION

Modifications are only available to students identified as having a disability. **To be entitled to an adjustment of the University's meal plan, a student must be determined to: (1) have a physical or mental impairment that substantially limits one or more major life activities; or (2) have a record of such an impairment; or (3) be regarded as having such an impairment.** Examples of major life activities are: 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.

1. **Based on this definition does the individual have a disability**? **YES** **NO**

2. **State the student's specific diagnosis/medical condition, including diagnostic code.**

3. **Is the student currently under your care?** **YES** **NO**

How long have you treated this patient? _____ Date of most recent office visit?_____

Date of original diagnosis: _____ Date of most recent evaluation: _____

4. **Is the disability mediated or controlled by medications or other treatments? YES NO**

   (Please explain)

5. **Summary of the procedures and laboratory results used to arrive at the diagnosis** (*please attach test results with this form, e.g. allergy testing, blood reports etc.):*

6. **What is the expected duration, stability, or progression of the disability/medical condition?**

7. **Explain in detail, severity and/or frequency of exacerbations, limitations of the student's illness/disability.**

8. **Has the student been treated in emergency room or hospital for this condition within past year?**

   YES NO

9. **Total number of hospitalization related to this condition within the past year: _____**

10. **Date of last hospitalization related to this condition: _____**

11. Provide a list of the diet restrictions for this student.

12. Please state specific recommendations for reasonable meal plan modification to address the functional limitations noted above.

THIS SECTION MUST BE COMPLETE FOR FORM TO BE VALID

Physician or disability evaluator INFORMATION **(Please Print)**

Name: _____

Title: _____ Specialty: _____

Office Address: _____

Phone: _____ Fax: _____ Email: _____

License/Certification Number and State of License _____

May we contact you if we have questions about this student's accommodation request? **YES** **NO**

Signature (verifying that you are not related to the student by blood or marriage): _____

Date: _____

PLEASE MAIL or FAX COMPLETED FORM TO:

For Florham Campus and Wroxton Campus:
Disability Support Services
Fairleigh Dickinson University
285 Madison Ave, M-MO1-01, Madison, NJ 07940
(973) 443-8079 (Office), (973) 443-8080 (fax)

For Metropolitan Campus:
Disability Support Services
Fairleigh Dickinson University
1000 River Road, T-RH2-09, Teaneck, NJ 07666
(201) 692-2076 (Office), (201) 692-2469 (fax)