MISSOURI VALLEY COLLEGE

Medical Statement for students Requesting Dietary Accommodations

Student Name_____Student DOB_____

Campus Address and Phone Number

_____

E-Mail_____

Medical Doctor Name_____

Medical Doctor Address and Phone Number_____

_____

_____I hereby authorize Missouri Valley College to receive information from the provider below. I also authorize my provider to discuss my condition with the appropriate Missouri Valley College (MVC) personnel on an as-needed basis.

_____I hereby authorize the Disability Service Office for MVC to communicate directly with the health provider who completes this form to obtain clarification of issues relating to the functional limitations for which I am seeking an accommodation.

<u>For Medical Doctor Use Only</u>

Food Allergy to Dairy_____Eggs_____Fish_____Peanut_____

Tree Nut_____Wheat_____Other_____(Please Specify)_____

_____

_____

Gluten Intolerance_____Lactose. Intolerance_____

Other_____

_____

Diet Prescription: Foods Omitted and Substitution

Please list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

Omitted Foods	**Substitutions**
_____	_____
_____	_____
_____	_____
_____	_____

Indicate Length of Time Dietary Accommodations will be required

On Going_____ Temporary_____

Start Date:_____End Date:_____

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

Medical Doctor Signature

_____

Date:_____

License #_____

Missouri Valley College Dietary staff use only

The cafeteria dietary staff has reviewed the Medical statement for

Student Name_____Student ID_____

_____The cafeteria at Missouri Valley College can accommodate this dietary requirement.

_____The cafeteria can not accommodate this dietary requirement and student should be released from meal plan.

Signature of Missouri Valley College Cafeteria Management staff

Signature:_____

Date:_____