Dining & Catering Services
Eastern Washington University

SPECIAL DIETARY ACCOMODATIONS FORM

Complete and submit this form only if you have a special dietary need and are requesting a Meal Plan modification.

CONTACT INFO

Last Name	First Name	MI	Date of Birth

□ Incoming Student □ Current Student	Email Address	Phone

Please have your physician complete, sign and date this portion of the form.

TO BE COMPLETED BY YOUR PHYSICIAN OR MEDICAL PROVIDER

Physician's Last Name	First Name	MI

Physician's Title	Physician's Phone Number

Medical Diagnosis of condition(s)

Assessment procedures and evaluation methods used to make the diagnosis

List student's possible reactions and/or symptoms related to the above-indicated condition(s)

Diet Prescription: □ Ongoing □ Temporary

Start Date: _____

End Date: _____

An epinephrine device has been prescribed and and should be carried by the student: □ Yes □ No

I certify that the above named student needs special dietary accomodatins as described above.

Physician Signature _____ Date _____

By signing below, I give my consent to authorize EWU Dining Services Dietitian and Disability Support Services Office to discuss, either in writing or orally, my special dietary need(s) with the appropriate EWU management, professionals, and staff, for the purposes of providing or coordinating needed services for me as it relates to me as a student at Eastern Washington University.

Student Signature _____ Date _____

Please return completed Form:

Disability Support Services, 121 Tawanka Hall, Cheney, WA, 99004 or Fax 509-359-7458

For Questions on filling out this form contact *Dining Services dietitian at jyonago@ewu.edu or 509-359-6624*