Dillard University Dining Requests
DiningRequest@dillard.edu

Dillard University Dining Requests
Documentation Form for Medical Providers

Please have your physician complete this form or provide a letter from your physician that answers all of the questions on this form. Please submit in a sealed envelope and hand delivered or mailed to Michelle Matthew, Auxiliary Services, Kearny Hall, Room 111, Dillard University, 2601 Gentilly Blvd, New Orleans, LA 70122. OR the scanned documents may be sent via email attachment to DiningRequest@dillard.edu

Name of Student: _____ DOB _____/_____/_____

Name of Medical Professional Completing this form _____

Title/Credentials of Professional Completing this form _____

Address _____

City _____ State _____ Zip _____

Date of initial contact with the named student? _____

Name of Medical Professional Evaluator (if different) _____

Title/Credentials of Professional Evaluator _____

1) What is the student's current diagnosis?_____
2) Does this medical condition require a specific diet? _____
3) Severity of the condition: _____ Mild _____ Moderate _____ Severe
4) Date of initial diagnosis: _____
5) Is this student currently under your care? _____ Yes _____ No
6) If yes, length of time under your care and frequency _____
7) Please list current medications including dosage: _____

   _____

8) Please list the necessary dietary modifications to meet the student's medical needs. Examples include: Gluten Free, Low Carbohydrate, Nut Free, Low Cholesterol, Shellfish Free, Low Fat, Lactose Free, Gastrointestinal Diet (Crohn's, Colitis, IBS), Soy Free, Diabetic Diet, Vegetarian, High Protein, Low Calorie, Other (please describe):

   _____

   _____

   _____

9) Please provide a detailed account of the dietary needs including foods the student can and cannot eat.

_____

_____

_____

10) Please describe the type, severity, and frequency of symptoms as related to the diagnosis, and how the condition interferes with the student's ability to eat in a dining hall.

_____

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Medical Provider Name: _____

Medical Provider Signature: _____

Date: _____

Practice Name: _____

Address: _____

_____

Phone Number: _____