KANSAS STATE UNIVERSITY | Housing & Dining Services

Special Dietary Accommodations Form

Student Name	**WID**
Campus Address and phone number	**E-mail**
Permanent address	**Emergency Contact Information**
Physician Name	**Physician address, phone number, and fax**

For Completion by Physician (M.D. or D.O.)

Food Allergies and Medical Conditions (please check all that apply)

Food Allergy to: ☐ Dairy ☐ Egg ☐ Fish ☐ Peanut ☐ Shellfish ☐ Soy

☐ Tree Nut ☐ Wheat ☐ Other (Please specify):

Gluten Intolerance ☐

Other Medical Conditions which Require Dietary Accommodations by K-State Dining Services?_____

_____

Diet Prescription: Foods Omitted and Length of Special Dietary Accommodations

Please list specific food(s) to be omitted. You may attach an additional sheet if necessary which must be signed and dated by the physician.

Omitted Foods:

☐ **Ongoing** ☐ **Temporary**

Start Date: _____

End Date: _____

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

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

Physician Signature _____ Date:_____

By signing below, I give my consent to release/share this information among Kansas State University Housing and Dining Services management and hourly full-time and student staff.

Student Signature:_____ Date:_____