KU Dining Services

Medical Statement for Students Requesting Dietary Accommodations for Medical Reasons

Student Name	**Student DOB**
Campus Address and Phone Number	**E-Mail**
Permanent Address	**Emergency Contact Information**
Medical Doctor Name	**Medical Doctor Address and Phone Number**

For Medical Doctor Use Only

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 requiring Dietary Accommodations (Please Specify):_____

_____

Diet Prescription: Foods Omitted and Substitutions

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 Special Dietary Accommodations will be required

☐ Ongoing ☐ 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 _____