



## Boston University Disability & Access Services

### Disability Verification Form – Food Related Medical Conditions

The Disability & Access Services provides academic accommodations and services to students with **Food-Related Medical Conditions**. Students seeking accommodations must provide appropriate documentation of their disability so that Disability & Access Services can determine the student's eligibility for accommodations; and if the student is eligible, determine appropriate academic and dining accommodations. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities. Submitting evidence of a diagnosis, or a prescription alone, is not sufficient to warrant academic and dining accommodations.

To verify the disability and its severity, Disability & Access Services requires the following current documentation from a physician or other medical specialist with experience and expertise in the area related to the student's disability.

Documentation should include:

- A **current** clear statement of disability including diagnosis. Current documentation is dependent upon the student's condition and the nature of the student's request for accommodations. Documentation should also note the status of the individual's impairment (static or progressive).
- Disabilities that are sporadic or change over time may require more frequent evaluations. Documentation that reflects the *current* impact on the student's functioning should be submitted. **Present symptoms** that meet the criteria for the diagnosis must be present and noted.
- A narrative **clinical summary** of assessment procedures that were used to make the diagnosis, evaluation results, history of food-related medical condition and list of recommended accommodations to address each limitation
- A description of how current functional limitations will present in an academic environment.
- The diagnostic report must include the **name, and title, and license** number of the evaluator.
- A complete Disability Verification Form (please do not write "see attached")

Further assessment by an appropriate professional may be required if other co-existing disabling conditions are indicated. All documentation must be submitted on the official letterhead of the professional describing the disability. The report should be dated and signed and include the name, title, and professional credentials of the evaluator, including information about license or certification. ODS will make the determination regarding whether accommodations are reasonable in the University environment.

**All documentation is considered confidential and can be mailed or faxed to:**

Disability & Access Services

25 Buick Street Suite 300

Boston, MA 02215

Phone: 617-353-3658 Fax: 617-353-9646

[access@bu.edu](mailto:access@bu.edu)

[www.bu.edu/disability](http://www.bu.edu/disability)



## Boston University Disability & Access Services

### Disability Verification Form – Medical/Mobility Impairments

This form is intended to assist your client in meeting the documentation requirements for requesting academic and dining accommodations on the basis of a **food-related medical condition** at Boston University. Please fill out all of the questions on the below form, even if the material has been included in your full evaluation and/or clinical summary. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities.

All information will be kept confidential. Please feel free to contact ODS at (617)353-3658 with any questions.

**Please note:** All appropriate documentation must be received prior to formal review process commencing. Also, please be aware that provision of accommodations in high school, other non-BU academic institution or on any standardized test does not guarantee that the same or any accommodations will be awarded at Boston University.

**Student Name:**

Name: (please print) \_\_\_\_\_ BU ID: \_\_\_\_\_

**For the current treating healthcare provider to complete:**

**1. Diagnosis: Please list all relevant diagnoses.**

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a. Approximate onset of diagnosis

Child - approximate age: \_\_\_\_\_

Adolescent - approximate age: \_\_\_\_\_

Adult - approximate age: \_\_\_\_\_

b. Date of your last clinical contact with student: \_\_\_\_/\_\_\_\_/\_\_\_\_

**2. Evaluation**

a. How did you arrive at this diagnosis?

Blood work

Skin Prick Test

Oral Food Challenge

Trial Elimination Diet

Breathe Test o Biopsy

Endoscopy

Gastric Emptying test

Upper Gastrointestinal Series

Other (Please specify). \_\_\_\_\_

b. Evaluation Results

c. Expected duration of food-related medical condition.

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d. Current treatment being received by student:

Medication management:

Please Specify: \_\_\_\_\_

Diet Prescription

Other (please describe): \_\_\_\_\_

e. Severity of symptoms:

Mild

Moderate

Severe

f. Prognosis of disorder:

Good

Fair

Poor

g. History of Hospitalizations \_\_\_\_\_

**3. Functional Limitations** Y  N

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a. Please describe in detail any functional limitations that fall into the significant range.

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b. Please list current medications.

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c. Special considerations, e.g. medication side effects:

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**4. Coexisting Conditions**

Please provide details about any coexisting learning, medical or psychiatric conditions. Please include all relevant reports.

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**5. Past Accommodations**

Please indicate whether student has utilized accommodations in the past. Y  N

Please describe:

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**6. Suggested Accommodations**

Please list the specific academic and/or dining accommodations you suggest based on your assessment of the students clinical and academic history and diagnosis. Include information about foods to be omitted, appropriate substitutions, issues with cross contact, preparation and storage.

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7. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

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**Thank you** for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned to ODS at the address shown at the end of this document.

**PLEASE NOTE:** To provide documentation of a **Food-Related Medical Condition**, the diagnosing professional must be a physician or other medical specialist with experience and expertise in the area related to the student’s disability.

**Provider Information**

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

If filling out online, in lieu of signature, please click here to certify that the above statement is true.

Y  N

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

State of License \_\_\_\_\_: License Number: \_\_\_\_\_

Address: \_\_\_\_\_

Street or P.O. Box City State Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please return this signed form to:**

Disability & Access Services,  
25 Buick Street Suite 300  
Boston, MA 02215  
Phone: 617-353-3658  
Fax: 617-353-9646