MONTANA STATE UNIVERSITY
Office of Disability Services

Special Dietary Requests

PHONE: (406) 994-2824 • **FAX:** (406) 994-3943 • **EMAIL:** drv@montana.edu

FOR STUDENT USE ONLY

Students — please fill in the information requested ***in this section only***. After printing, give the form to your physician to complete, specifying your dietary needs. Have your physician fax the form to the Office of Disability Services. ***Once this form has been received from your physician, an email detailing your next steps will be sent to your email account.***

Full Name _____ _____ Meal Plan (*check one*) ◯ Gold ◯ Copper ◯ Silver ◯ Bronze
Last (family) *First (given/preferred)*

Local Address _____

Telephone Number (_____) - _____ - _____ Best Time(s) to Call _____

Email Address _____ Student Year _____ Student ID# _____

FOR PHYSICIAN USE ONLY

Physicians — please check all that apply.

◯ Milk Allergy	◯ Soy Allergy	◯ Diabetes	◯ Other (*please note*)
◯ Lactose Intolerance	◯ Peanut Allergy	◯ Diverticular Disease	_____
◯ Wheat Allergy	◯ Tree Nut Allergy	◯ Crohn's Disease	_____
◯ Gluten Free	◯ Fish Allergy	◯ Irritable Bowel Syndrome	_____
◯ Celiac Disease	◯ Shellfish Allergy	◯ Ulcerative Colitis	_____
◯ Egg Allergy	◯ Oral Surgery	◯ Short Bowel Syndrome	_____

Printed Name and Title of Physician _____

Address _____ Telephone Number (_____) - _____ - _____

Physician's Signature _____ Date _____

PHYSICIAN NOTE

Please answer the following questions using official letterhead of treating physician.

- What are the patient's possible reactions to the above-indicated allergen(s) or conditions?
- What are the medically necessary dietary accommodations to ensure a safe experience while dining with us?
- What is length of time a special diet will be required ◯ Ongoing ◯ Temporarily from _____ until _____
- Is the patient currently undergoing continuing physician's care? ◯ Yes ◯ No

Office of Disability Services Use Only

Dietary Needs Form received on _____ Student appointment set for _____

Notes: