Medical Provider Verification of a Medical Condition Requiring an Alternative Dietary Accommodation

NORTHERN ILLINOIS UNIVERSITY
Campus Dining Services
Division of Student Affairs

I, (print name) _____

Date of Birth: _____ ZID: _____

allow my Medical Provider to provide the necessary information related to my alternative dietary need to Northern Illinois University.

Signature of Student, 18 and over: _____ Date: _____

Parent/Guardian Signature, student under 18: _____ Date: _____

Parent/Guardian Name (print): _____ Relationship: _____

Medical Provider: Please complete. Scan and email completed form to Meg Burnham, Registered Dietitian Nutritionist at mburnham2@niu.edu. Physical copies can be returned in person to Neptune Central room 223.

Please check all that apply:

	Allergy	Intolerances	Anaphylactic
Gluten	☐	☐	☐
Wheat	☐	☐	☐
Egg	☐	☐	☐
Dairy	☐	☐	☐
Soy	☐	☐	☐
Peanut	☐	☐	☐
Tree Nut	☐	☐	☐
Shellfish	☐	☐	☐
Fish	☐	☐	☐
Sesame	☐	☐	☐
Additional allergies or intolerances.			
	☐	☐	☐
	☐	☐	☐

Other medical conditions requiring an alternative dietary accommodation:

Medical Condition	Alternative Dietary Need

Diet Prescription or Other Notes: _____

_____

Name of Medical Provider, Practice/Group: _____

Address: _____ Phone: _____ Fax: _____

Medical Provider signature: _____ Date: _____