

## **Reinhardt University Meal Plan Accommodations for Dietary Restrictions:**

### **Policy and Procedure**

Campus dining is a significant part of the Reinhardt University experience, and all residential students are required to purchase a campus meal plan. Reinhardt University provides accommodations for qualified students with food allergies or other health-related dietary restrictions. Dining Services works with students to help them meet their special dietary needs and will assist students with food allergies to make their own food choices. Some food allergies and intolerances may also be managed independently within the dining locations

Students who have health-related dietary restriction must register with the Academic Support Office and submit appropriate medical documentation. The documentation of the dietary restriction should include specific recommendations from a licensed health care provider who has worked with the student to address the problem and who is not a family member. Students should send the relevant documentation to the Academic Support Office by email (AAA@reinhardt.edu) or by fax to 770-720-5602. After registering, students will receive a “Dining Services/Health Center Contact Form”. The form should be completed and returned to the Academic Support Office. The form and any related documentation will be kept on file at the Academic Support Office.

Students who would like further assistance with the clinical management of their dietary needs are encouraged to make an appointment with the nurse.

#### Procedure Checklist:

- Contact the Academic Support Office at (770)-720-5567 to register and to schedule an appointment in person or by phone to discuss the process, arrange to sign a release and receive the Dining Services/Health Center Contact Form.
- Submit documentation from a licensed professional who has worked with the student to address the problem and who is not a family member.
- Once Academic Support has decided about the accommodation request, it may recommend that the student schedule an appointment with the Director of Health Center. If so, the director of Dining Services and/or the Health Center will complete a contact form which the student will return to the Academic Support Office
- Students with any questions or concerns about their accommodation plan should speak with the director of Academic Support.

**Reinhardt University Dietary Based Disability Documentation Form**

To be Completed by student's Health care professional

Reinhardt University is committed to the full participation of students with disabilities in all aspect of college life, including dinning experience. A major facet of living at a residential college is dining together, and the opportunity for developing a sense of community that arises in the setting. To this end, all students living on campus are required to have a meal plan. Occasionally, students have special needs based on documented health conditions, such as those resulting in certain dietary needs, which may necessitate a dietary accommodation.

Please confirm that this student has authorized you to provide the Reinhardt Dietary Accommodations Committee with any follow-up information we may need regarding this students' meal plan accommodation request. Thank you for your responses to the questions below.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Care Provider Information**

Provider's Name: \_\_\_\_\_ Practice Name: \_\_\_\_\_

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

Email: \_\_\_\_\_

Telephone: \_\_\_\_\_

1. Under the ADA, this individual has a.....(please select) \_\_\_\_\_ Disability \_\_\_\_\_ Temporary Impairment

2. Please cite the student's diagnosis:

Dx#1: \_\_\_\_\_ Diagnostic Code: \_\_\_\_\_

Dx #2: \_\_\_\_\_ Diagnostic Code: \_\_\_\_\_

Dx #3: \_\_\_\_\_ Diagnostic Code: \_\_\_\_\_

From the:

\_\_\_\_\_ DSM-IV-TR \_\_\_\_\_ DSM-V \_\_\_\_\_ ICD-9 \_\_\_\_\_ ICD-10

3. This condition is..... \_\_\_\_\_ Permanent \_\_\_\_\_ Temporary Duration: \_\_\_\_\_

4. Date of Diagnosis: \_\_\_\_\_ Made by you: \_\_\_\_\_ Yes \_\_\_\_\_ NO

If No, Dx made by: \_\_\_\_\_

5. Number of consultations with you in the past 3 years: \_\_\_\_\_ Length of Time under your care: \_\_\_\_\_

6. Currently under your care: \_\_\_\_\_ Yes \_\_\_\_\_ NO, care ended on: \_\_\_\_\_

7. Prescription medication: \_\_\_\_\_

8. Side effects of medication: \_\_\_\_\_

9. Please describe the type, severity, frequency of symptoms currently experienced by the student, and how the disability interferes with eating/dining in college facilities.

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10. Please indicate which modification you believe are necessary to accommodate the student's medically necessary dietary needs:

\_\_\_\_\_ Access to Gluten free section

\_\_\_\_\_ Access to Dairy Free menu options

\_\_\_\_\_ Specialized diet for Gastrointestinal Diseases

\_\_\_\_\_ Specialized Diets for Diabetes

\_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Explain how this alternative to the standard meal plan would affect the student's underlying conditions:

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12. Any further comments you feel the Dietary Accommodation Committee should be aware of?

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13. \_\_\_\_\_ I have attached the documentation with the results of evaluation which led to this diagnosis.

My signature verifies that I am or have been this student's treating health care professional, that the contents are true and accurate, and that I am not a relative of the student

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

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

**Reinhardt University Meal Plan Accommodation for Dietary Restrictions:  
Dining Services/Health Center Contact Form**

**Health Center**

I, \_\_\_\_\_, met with \_\_\_\_\_

on \_\_\_\_\_ to discuss his/her dietary needs. As a result of our conversation, we have come to the following determination:

\_\_\_\_ We have developed the following plan for his/her dietary needs at Reinhardt University

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\_\_\_\_ The student should follow up with the appropriate office to discuss reasonable meal plan accommodations.

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

**Dining Services**

I, \_\_\_\_\_, met with \_\_\_\_\_

on \_\_\_\_\_ to discuss his/her dietary needs. As a result of our conversation, we have come to the following determination:

\_\_\_\_ We have developed the following plan for her//his dietary needs at Reinhardt University.

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\_\_\_\_ The student should follow up with the appropriate office to discuss reasonable meal plan accommodations.

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