BALL STATE UNIVERSITY DINING

HAVE QUESTIONS? CONTACT JACOB BROOKS VIA E-MAIL AT jtbrooks2@bsu.edu OR BY PHONE AT 765-285-2116.

Full Name..... _____ BSU Meal Plan _____

Local Address ..... _____

Telephone Number ... _____ Best times to call (1) _____ (2) _____

BSU E–mail Address _____ BSU Student Year _____

STUDENT NOTE: Fill in the information requested above before printing the form. After printing, give the form to your physician to complete the following, specifying your dietary needs, and please have your physician send to Jacob Brooks via email: jtbrooks2@bsu.edu or fax: 765-285-3713. An appointment will then be set to discuss your specific needs in detail.

FOR PHYSICIAN'S USE ONLY–Please check all, that apply

- ☐ Dairy Allergy
- ☐ Lactose Intolerance
- ☐ Wheat Allergy
- ☐ Gluten Intolerance
- ☐ Celiac Disease
- ☐ Egg Allergy
- ☐ Soy Allergy
- ☐ Peanut Allergy
- ☐ Tree Nut Allergy
- ☐ Fish Allergy
- ☐ Shellfish Allergy
- ☐ Corn Allergy
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Short Bowel Syndrome
- ☐ Oral Surgery
- ☐ Other, please note _____

What are the patient's possible reactions to the above-indicated allergen(s) or conditions?

What are the medically necessary accommodations to help manage the health of the patient?

Indicate the length of time a special diet will be required:

☐ Ongoing ☐ Temporarily from _____ till _____

Is the patient currently under continuing physician's care? ☐ Yes ☐ No

Date of last visit _____

Printed Name and Title of Physician: _____

Address: _____

_____

Phone Number: _____-_____-_____ _____

Physician's Signature and Date

When completed, please send to Jacob Brooks via email: jtbrooks2@bsu.edu or fax: 765-285-2116

FOR BSU DINING USE ONLY

The *Dietary Needs Information Form* was received on _____

Student appointment was set for _____

Notes: