



NORTHERN ILLINOIS UNIVERSITY

Campus Dining Services

Division of Student Affairs

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

Patient Name: _____

Date of Birth: _____ zID: _____

I hereby allow my medical provider to provide the necessary information related to my alternate dietary need to Northern Illinois University.

Signature of Student If Over 18: _____ Date: _____

Parent/Guardian Signature If Student Is Under 18: _____ Date: _____

Parent/Guardian Name: _____ 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.

Top 9 Food Allergens	Allergy	Intolerance	Anaphylactic
Gluten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Egg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peanut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tree Nut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shellfish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sesame	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list additional food allergies, intolerances and anaphylaxis.

Food	Allergy	Intolerance	Anaphylactic
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list all other medical conditions requiring an alternative dietary accommodation.

Medical Condition	Alternative Dietary Need

Diet Prescription or Notes: _____

Name of Medical Provider, Practice/Group: _____

Address: _____

Medical Provider Signature: _____ Date: _____