

Food Allergy Verification Form

East Carolina University's Campus Dining, Student Health Services and Disability Support Services are committed to supporting students with food allergies by providing an array of food choices as well as the knowledge necessary to make informed choices. This form should be completed by your Medical Doctor or Allergist.

To be completed by the student:

Name: _____

By my signature below I hereby authorize my health care provider _____ to furnish the following information to Disability Support Services (DSS) at East Carolina University. I further agree that DSS or Student Health Services may contact my health care provider named above to obtain additional information related to my limitations and recommended accommodations.

Signature

Date

To be completed by the health care provider:

Please indicate which of following food groups may cause an allergic reaction and indicate the severity:

Peanuts	mild	moderate	severe
Tree Nuts	mild	moderate	severe
Fish	mild	moderate	severe
Shellfish	mild	moderate	severe
Soy	mild	moderate	severe
Milk	mild	moderate	severe
Eggs	mild	moderate	severe
Wheat	mild	moderate	severe
Other:			
_____	mild	moderate	severe
_____	mild	moderate	severe
_____	mild	moderate	severe

Is the student prescribed an Epi-Pen? Yes No

In the case of a reaction, how has the student been instructed to respond:

___ administer Epi-pen

___ call 911

___ take prescribed oral medications

Other:

Provider Information

Name: _____ Area of specialty: _____

Practice Address: _____

Phone: _____ Fax: _____

Signature

Date