



## DIETARY RESTRICTIONS DISABILITY VERIFICATION FORM

**TO BE COMPLETED BY TREATING HEALTHCARE PROVIDER:** *The student named below is requesting accommodations on the basis of a disability at Pomona College. The information provided here is confidential and will not become part of the patient's educational records.*

### SECTION 1: STUDENT INFORMATION

*Pomona College has deemed it mandatory for all students to be on a meal plan. Occasionally, students have special needs, which may necessitate accommodations to the meal plan. Exemption from participation in the meal plan is rare and will only be considered when needs cannot be accommodated by Pomona College Dining Services. Please provide as much detail as possible to help us determine appropriate accommodations.*

STUDENT NAME: \_\_\_\_\_ ID: \_\_\_\_\_ BIRTHDATE (MM/DD/YYYY): \_\_\_\_\_

### SECTION 2: DIAGNOSTIC INFORMATION

1. DIAGNOSIS: \_\_\_\_\_ DSM/ICD CODE: \_\_\_\_\_

ONSET DATE: \_\_\_\_\_ SEVERITY: MILD    MODERATE    SEVERE    IN REMISSION

ANTICIPATED DURATION: CHRONIC/PERMANENT    TEMPORARY; EXPECTED TO LAST: \_\_\_\_\_

2. DIAGNOSIS: \_\_\_\_\_ DSM/ICD CODE: \_\_\_\_\_

ONSET DATE: \_\_\_\_\_ SEVERITY: M



**Accessibility Resources & Services**  
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Email: Disability@pomona.edu

PLEASE EXPLAIN HOW THE DISABILITY INTERFERES WITH THE STUDENT PARTICIPATING IN THE COLLEGE'S MEAL PLAN AND/OR EATING IN THE COLLEGE'S DINING FACILITY