UNIVERSITY OF
NORTHERN COLORADO
Disability Support Services

Severe Food Allergy Documentation Form

To be completed by the student's treating physician for allergies. All items are required. Please print legibly. This form may NOT be completed by the student or a relative of the student.

To assist Disability Support Services (DSS) and UNC's Dining Services in determining reasonable and appropriate disability accommodations, please complete the form below by:

May 1 for First-year students and New Transfers
March 1 for Continuing and Returning Students

Name: _____ DOB: _____ Date: _____

Diagnosis, History, and Current Status:
Date of initial allergy diagnosis: _____
Date of last office visit for this condition: _____

What triggers the student's severe allergy?

What symptoms does the student exhibit in reaction to the severe allergy?

Procedures/assessments used to diagnose this student's condition (attach copies of assessment results used in making/confirming diagnosis)

Check the foods that have caused an allergic reaction:

- ☐ Peanuts
- ☐ Peanut or nut butter
- ☐ Peanut or nut oils
- ☐ Fish/Shellfish
- ☐ Eggs
- ☐ Milk and/or Dairy
- ☐ Soy Products
- ☐ Tree Nuts (walnuts, almonds pecans, etc.)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

How many times has the student had a reaction? Please explain. (Never, once, more than once, etc.)

When was the last reaction? _____

Are the food allergy reactions staying the same, getting worse, getting better?

Please indicate the severity of the condition: **Mild** **Moderate** **Severe**

Student is compliant with medical treatment of condition:
Rarely **Sometimes** **Often** **Unknown**

Does the student take prescription medications for this condition? **Yes** **No**
If yes, please list: _____

Has the student been prescribed an Epi-Pen? **Yes** **No**

If yes, do you recommend the student carry it with them at all times? **Yes** **No**

Has the student been treated in an emergency room for this condition within the last year?
Yes **No**

Has the student been hospitalized for this condition within the last year? **Yes** **No**

Does the student have asthma? **Yes** **No**

Limitations Caused by the Condition:
Describe how the allergy limits the student's day-to-day activities (i.e., breathing, eating, environmental, etc.).

How often does the student experience the above limitation(s)?
Rarely **Occasionally** **Frequently**

Describe any substantial equipment prescribed for this student's home or school environment.

Recommendations for the health-care management of this condition:

Recommended accommodation(s). Recommendations must be clearly linked to the limitations described above.

By signing this form, the Health Care Provider agrees that the form was filled out and completed by the clinic/medical staff treating the patient.

Physician Signature and Information:

Physician Name: _____

Date: _____

Physician Signature: _____

Address: _____

Specialty: _____ License/Cert #: _____

State: _____ Phone: _____ Email: _____

FAX: _____