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 ____________________