Medical Statement for Students Requiring Special Dietary Assistance

Pioneer College Caterers
Indiana Wesleyan University
4201 S. Washington St.
Marion, IN 46953

Student Name		DOB
Campus Address		ID #
Home Address		Phone
City	State	Zip
Parent, Gaurdian or Emergency Contact (per student authorization)		
Name		
Home Phone	Work Phone	
Physician Name		Phone

FOR PHYSICIANS USE ONLY

Medical Disease & Condition

___	Dairy Allergy	___	Celiac Disease	___	Gluten Intolerance
___	Corn Allergy	___	Dermatitus Herpeform	___	Diabetes
___	Egg Allergy	___	Diverticular Disease	___	Chronic Kidney Disease
___	Fish Allergy	___	Irritable Bowel Syndrome	___	Cystic Fibrosis
___	Peanut Allergy	___	Crohn's Disease	___	PKU
___	Shellfish Allergy	___	Ulcerative Colitis	___	Oral Surgery
___	Soy Allergy	___	Short Bowel Syndrome	___	Other (Please Specify)
___	Tree Nut Allergy	___	Leak Gut Syndrome		______________________________
___	Wheat Allergy	___	Lactose Intolerance		______________________________

Diet Perscription

Food Omitted and Substitutions

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

Omitted Foods	Substitutions
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Indicate Length of Time Special Diet will be Required

___ Ongoing ___ Temporary Start Date ________________ End Date ________________

Indicate Texture (if applicable)

___ Regular ___ Chopped ___ Ground ___ Puree

Additional Comments/Remarks

____

____

I certify that the above named student needs special dietary assistance as described above, due to the student's medical disease and/or condition.

Physician's Signature: ____________________________ Printed Name & Title: ___________________________ Date: ________

Physician's Office Address:____ Physician's Phone Number:_________________