Special Dietary Needs Information Form

ONCE YOUR PHYSICIAN HAS COMPLETED THIS FORM, PLEASE HAVE THEM SUBMIT TO DISABILITY SERVICES AND PROGRAMS

THIS CAN BE DONE THROUGH THE MAIL, IN PERSON OR BY FAX (213-740-8216)

Should you have questions about how USC Hospitality can accommodate your special dietary needs, please contact Lindsey Pine MS, RDN, CSSD, CLT at lpine@usc.edu or 213-740-9901

Full Name of Student ______________________ Email Address ______________________

Local Address ____

Telephone Number ______________________ USC ID# ______________________

Which Meal Plan do you have? ____________ Which dining hall do you wish to frequent most often? ____________

Students: Please fill out the above information before giving to your physician.

FOR PHYSICIANS USE ONLY — Please Check All that Apply

- ☐ Dairy Allergy
- ☐ Lactose Intolerance
- ☐ Wheat Allergy
- ☐ Gluten Intolerance
- ☐ Celiac Disease
- ☐ Sesame Allergy
- ☐ Egg Allergy
- ☐ Soy Allergy
- ☐ Peanut Allergy
- ☐ Tree Nut Allergy
- ☐ Fish Allergy
- ☐ Shellfish
- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Oral Surgery

Other Food Allergies ______________________

Other Food Intolerances/sensitivities ______________________

Other ______________________

- What are the patient’s possible reactions to the allergen(s) or condition(s) listed above?
- What are the medically necessary dietary accommodations needed to manage the health of the patient?
- How long is the special diet required?
- Is the patient currently under continuing physician’s care?

Printed Name, Title & Credentials of Physician ______________________

Signature of Physician ______________________ Date ______________________

Address ______________________

Phone Number ______________________