

# 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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Dairy Allergy       | <input type="checkbox"/> Peanut Allergy           | Other Food Allergies _____                  |
| <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Tree Nut Allergy         | Other Food Intolerances/sensitivities _____ |
| <input type="checkbox"/> Wheat Allergy       | <input type="checkbox"/> Fish Allergy             | Other _____                                 |
| <input type="checkbox"/> Gluten Intolerance  | <input type="checkbox"/> Shellfish                |   |
| <input type="checkbox"/> Celiac Disease      | <input type="checkbox"/> Crohn's Disease          |   |
| <input type="checkbox"/> Sesame Allergy      | <input type="checkbox"/> Irritable Bowel Syndrome |   |
| <input type="checkbox"/> Egg Allergy         | <input type="checkbox"/> Ulcerative Colitis       |   |
| <input type="checkbox"/> Soy Allergy         | <input type="checkbox"/> Oral Surgery             |   |

- 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 \_\_\_\_\_