

## Celiac/Gastrointestinal Disease Verification Form

East Carolina University's Campus Dining, Student Health Services and Disability Support Services are committed to supporting students with Celiac and other gastrointestinal disorders as they impact the nutritional options available on campus. This form should be completed by your Medical Doctor or Gastroenterologist.

**To be completed by the student:**

Name: \_\_\_\_\_ Banner ID: \_\_\_\_\_

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:**

Nature of the GI disease process: \_\_\_\_\_

Is the condition:                      mild                      moderate                      severe

Date of diagnosis: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Dietary restrictions imposed by the disorder, please be specific about foods that must not be ingested:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In case of exposure to restricted items, 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 : \_\_\_\_\_