Food Services @BU | BRANDON UNIVERSITY

Dining Accommodation Form

Instructions for the student

Sign PART C authorizing and directing your health care provider to disclose information to us. By signing PART C, you also authorize and direct us to disclose personal information related to your request to your health care provider, if necessary.
NOTES: Your health care provider must answer all applicable questions in Part D. Additional information may be requested and you may be required to meet with the University's nutritionist and food liaison officer or Health Services for an assessment.

A - Personal information

Surname	Given names	
Student number	email address	
Telephone number	Residence	Meal Plan
Do you have any other dietary restrictions? E.g. Vegan, vegetarian, lactose intolerant, etc.		

B – Reason for request (attach additional sheets if necessary)

C – Authorization

I HEREBY AUTHORIZE AND DIRECT________(*insert name of health care provider*) to disclose my personal health information related to my dietary restrictions by answering the questions in PART D and any related questions from the University's food service manager and nutritionist. I understand that such disclosure is for the sole purpose of substantiating my dietary restriction(s) and to provide the food service manager and nutritionist with the information necessary to assess my request for access to the dietary restriction program. While I may refuse to give such authorization and direction, I understand that doing so may result in my request being denied. **I FURTHER AUTHORIZE AND DIRECT** the food service manager and nutritionist to disclose my personal health information related to my request to my health care provider, if necessary.

Signature of student________________________________ Date_________________________

D – TO BE COMPLETED BY STUDENT'S HEALTH CARE PROVIDER (MEDICAL DOCTOR OR NURSE PRACTITIONER)

Please provide all requested information and answer all relevant questions.

Name_________________________________ License registration number _______________

1. Is there a diagnosis requiring dietary restrictions to food allergies? Yes / No
2. What dietary restrictions are required by this diagnosis? (list all allergens) ______________________
   ____
3. Has the patient been prescribed an epinephrine auto-injector? Yes / No

Additional comments ____

Signature ____Date_______________

Please send the completed form by fax, mail, email to:

Brandon University Residences 270-18th Street Brandon, Manitoba R7A 6A9, Canada
residence@brandonu.ca Tel: 204-727-7394 Fax: 204-727-4713

Notice of Collection of Personal Information

In accordance with relevant legislation and policies, including The Manitoba Human Rights Code, the Freedom of Information and Protection of Privacy Act and the Personal Health Information Act, all personal information relating to the dietary restrictions of students is to remain confidential. The personal information you provided in your request for admission to the dietary restriction program will be used by Food Services for purposes consistent with the handling of your request. If you have questions about the collection, use and disclosure of your personal information in this notice, please contact the Food Service Manager *at* 204-727-9670 *or* hamiltonk@brandonu.ca.