Meal Plan Exemption Form

*Return this form with the required documentation to **Disability Services.***

Student's Full Name: _____ Email: _____

Request Date: _____ Exemption Request Semester Fall: _____ Spring: _____

Meal Exemption Request (based on) Medical Condition: _____

STUDENT STATEMENT

By signing below, you affirm and agree to/that:

- All the policy and conditions listed in the Food Exemption Policy.
- All information provided by you and your care provider regarding your request is true and accurate.

Student's Signature: _____ Date: _____

PHYSICIAN STATEMENT

I understand that meal plan exemptions are based on significant or unforeseen medical conditions. The information I have submitted is accurate and should be taken into consideration when reviewing this student's record. I further understand that this information will be presented to the Director of the Disability Services, Student Health & Wellness Center and Food Services.

Describe the diagnosed medical condition a specific diet for:

Student's Full Name: _____

_____

_____

_____

_____

Please attach any lab and/or skin testing results used to determine diagnosis.

Physician's Signature: _____ Date: _____

Name (please print): _____ Phone: _____

Clinic/Hospital: _____

Address: _____