Medical Modification Request Form

This form is only a requirement for on-campus freshmen who are requesting a modification to their meal plan for medical purposes.

Name: ____________________________________
Email: ____________________________________
Student ID: _______________________
Phone: ___________________________

Current Meal Plan:  __All Access Diamond  __All Access  __12 Meals Per Week
  __ Block 160  __ Block 120  __ Block 80  __ Block 40

Desired Meal Plan:  __All Access Diamond  __All Access  __12 Meals Per Week
  __ Block 160  __ Block 120  __ Block 80  __ Block 40  __ None

I am requesting a meal plan modification for the following reason:

  ___ A. Medical: Please attach a letter fully describing your dietary requirements as well as the completed Physician Statement for Meal Plan Modification/Exemption form signed by your Physician.

  ___ B. Food Allergy: Please attach a letter fully describing your dietary requirements as well as the completed Physician Statement for Meal Plan Modification/Exemption form signed by your Physician.

  ___ C. Other: Please attach explanation regarding your dietary restrictions

RELEASE OF INFORMATION REQUEST TO BE COMPLETED BY STUDENT

I hereby authorize my treating physician to discuss and release all pertinent information to the College of Charleston (Campus Services, Disability Services and Residence Life) which relates to the accommodations that I have requested and to establish the validity of my request. This information will be used for the express purpose of determining meal plan accommodations and will not be released to anyone else, other than the aforementioned personnel.

• I have the right to inspect and receive copies of written information to be disclosed.

• The information disclosed as a result of this consent cannot be re-disclosed by the receiving agency/facility/person to anyone not permitted by this release, unless I specifically authorize it.

• I understand that if I refuse to consent to this disclosure of information my request will be incomplete.

• My signature indicates the statements/documentation I have provided are true and accurate.

Student Signature  ____________________________  Date  ________________

Please submit this form via email or in person to
Dining Services: diningservices@cofc.edu or 65 George Street.
843.953.5539