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: ____________________________________  Student ID: ______________
Email: ____________________________________  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: campusservices@cofc.edu
65 George Street | 843.953.5539