Disability Resources
100 College Drive
Allentown, PA 18104
1-610-606-4628
fax: 610-606-4673
www.cedarcrest.edu

Meal Plan Accommodation Request Form

Cedar Crest College is deeply committed to the full participation of students with disabilities in all aspects of college life, including dining experiences. Students living in the residence halls may be required to purchase a meal plan. Occasionally, students have special dietary requirements that are medically necessary; many times, these needs can be met by Dining Services.

Meal plan accommodations are rare and are made solely for students with documented health conditions that require medically necessary diets that cannot be accommodated by Dining Services. In the rare instance that Dining Services is unable to meet the student's medically necessary dietary needs, the student may be granted a meal plan reduction or exemption.

NOTICE: Students and Medical Professionals - By signing this form, the student is authorizing their treating medical professional to provide the Cedar Crest College Accommodation Review Committee any follow-up clarification or information the Committee may need to make a determination regarding the student's meal plan accommodation request.

Student Name:_____**CCC Student ID:** _____

Campus Residence: _____ **Class (circle one): Fr Soph Jr Sr**

Accommodation Request (choose one):

- ☐ Reduction in Meal Plan: from _____ plan to _____ plan
- ☐ Meal Plan Exemption

Student Signature:_____**Date:** _____

MEDICAL INFORMATION – To Be Completed by the Qualified Medical Provider

Is the student currently under your care?_____YES_____NO

Length of time under your care:_____**Date of most recent evaluation:** _____

If no longer under your care, when did care end? _____

Diagnosis*:_____**Date of Diagnosis:** _____

ICD-9/10 Code:_____**Was the diagnosis made by you?**_____YES_____NO

If not, by whom? _____

Is this condition permanent?_____YES_____NO**, the expected duration of the condition is:** _____

***PLEASE ATTACH DOCUMENTATION WITH THE RESULTS OF EVALUATIONS/TESTING WHICH LED TO THIS DIAGNOSIS**

Please describe the type, severity, and frequency of symptoms currently experienced by the student, and how the condition interferes with eating or dining in college facilities.

What foods or types of food should be avoided and WHY? Please be specific and list any food allergies.

Explain how avoiding these foods would impact the symptoms the student is experiencing.

Signature of Provider: _____**Date:** _____

My signature verifies that I am or have been this student's treating health care provider, that I have personally completed this form, that the contents are true and accurate, and that I am not a relative of the student.

PROVIDER'S CERTIFICATION & PROFESSIONAL INFORMATION *Please Print*

Provider's Name (Please Print): _____

Practice Name: _____

License Type: _____ License Number:_____ State of Licensure: _____

Address: _____ State: _____ Zip Code: _____

PLEASE MAIL COMPLETED FORM TO: Disability Resources
Cedar Crest College, 100 College Drive, Allentown, PA 18104