



MEAL PLAN WAIVER DUE TO MEDICAL CIRCUMSTANCES

TO BE COMPLETED BY LICENSED PHYSICIAN OR MEDICAL SPECIALIST. OFFICE STAMP REQUIRED.

Name of Student: _____ Student ID # _____

E-mail address: _____ Cell Phone # _____

1. What is the student's medical condition/diagnosis? _____

2. How long has the student had this condition? _____

3. Describe the student's current treatment plan (including any medications or special diet): _____

4. Based on the student's current medical condition, please indicate the specific dietary requirement you recommend:

5. Please provide comment as to how the special dietary requirement requested will meet the student's needs based on the medical condition described: _____

SIGNATURE AND OFFICE STAMP REQUIRED BY LICENSED PHYSICIAN OR MEDICAL SPECIALIST
Affix office stamp below

Signature

OFFICE USE ONLY

Request Reviewed: Date _____ Approved _____ Denied _____ Pending _____

By _____

Student Notified: Date _____ By: E-Mail _____ Letter _____

Dining Services Notified: Date _____ By: E-Mail _____ Letter _____

Please return this completed form to: **Clarendon College Dean of Students
P.O. Box 968
Clarendon, TX 79226**