Phone (843) 863-7159 • Strom Thurmond Building, Student Success Center • Fax (843) 863-8030 • awatson@csuniv.edu

Documentation for Meal Plan Accommodation

To be completed by the diagnosing professional, who should not be a relative of the student.

PLEASE PRINT

Student's Name: _____ Date of Birth: _____

Diagnosis: _____ Date of Diagnosis: _____

Date of Initial Contact with Student: _____ Date of last visit: _____

Is the condition ◯ permanent? ◯ temporary?

If temporary, what is the anticipated length of disability? _____

Briefly describe (print) the student's medical condition and dietary limitations.

Diagnostic criteria/test used:

Treatments/medications/devices or resources currently prescribed (name of medication and dosage):

Expected duration, stability, progression, or severity of the condition:

Is the student functionally impaired by one or more of the above listed conditions? ◯ Yes ◯ No

If yes, specifically describe how the condition contributes to functional impairments or limitations to the student's dietary needs.

What type of dietary accommodation (s) does the student need?

_____ _____
Signature of Health Professional Date

_____
Credential License # of Health Professional

Name and address of Health Professional (please print)

Phone:

Fax:

Please Return to:

Office of Disability Services/Strom Thurmond Building
Charleston Southern University
9200 University Boulevard
Charleston, SC 29423
Phone: 843.863.7159
Fax: 843.863.8030