



LORAS COLLEGE

Health Center

1450 Alta Vista St. | Dubuque, IA 52001 | Phone: (563) 588-7142 | Fax: (563) 588-7659

Meal Plan Accommodations Application

To be Completed by the Attending Physician or Specialist

Student Name: _____ Birthday: _____ Residence Hall: _____ Room: _____

1. Semester requesting meal plan change to begin: _____ Sport: _____

2. How long has this student been under your care: _____

3. Diagnosis: _____

4. Symptoms: _____

5. Medications: _____

6. Meal Plan being requested: _____

7. How has the student managed their dietary needs living in the residence hall: _____

8. Has the student met with a dietician: Yes No Explain: _____

9. Recommendations to assist the student in managing their symptoms: _____

10. Would there be a permanent negative health impact if the request to change meal plans is denied: Yes No

Explain: _____

11. Is the medical condition life threatening if the request to change meal plans is denied? Yes No

Explain: _____

SIGNATURE, DATE AND OFFICE STAMP ARE REQUIRED FROM THE ATTENDING PHYSICIAN OR SPECIALIST

Signature

Date

Office Stamp: