DAKOTA STATE
OFFICE OF DISABILITY SERVICES

Meal Plan Accommodation / Exemption Request

Before You Begin: Important Notes

To help ensure a smooth and timely review of your request, please read the following before completing this form.

1. **Deadlines**
    a. **Fall Semester:** Friday following the first day of classes
    b. **Spring Semester:** Friday following the first day of classes
    Requests received after these deadlines will be reviewed for the following semester unless a new medical or disability-related need arises mid-term.
2. **Required Documentation**
    c. Requests based on **medical needs** must include the **Physician's Form** completed by a licensed medical provider (MD, DO, NP, or ND).
    d. Requests based on **religious observance** must include the **Religious Leader Form** with a supporting statement and contact information.
    e. Correspondence from chiropractors, herbalists, or other non-licensed providers cannot be accepted.
3. **Important Process Details**
    f. Exemptions are granted **only when Dining Services cannot meet documented medical or religious needs**.
    g. All meal plan charges remain valid until a decision is communicated; approved exemptions are **prorated from the approval date**.
    h. Students must **reapply each academic year** with documentation dated within the past six months.
    i. False or misleading statements may result in disciplinary action under the Student Code of Conduct.
4. **Next Steps**
    j. Completed forms should be submitted through **Accommodate** or emailed to **dsu-ada@dsu.edu**.
    k. The student must meet with the **Campus Dietitian** before a decision can be finalized.

For the full set of guidelines, policies, and FAQs, please visit:
https://dsu.edu/student-life/disability-services/

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Student Information

First Name:_____ Last Name:_____

DSU ID#: _____ DSU Email: _____

Phone Number:_____ Current Meal Plan: _____

Your Class Year:_____

Describe why you are request a meal plan exemption/accommodation. Please provide specific information:

When did your symptoms first begin? _____

When did you first seek treatment? _____

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Authorization

Please mark each box beside each of the following items and sign below to indicate your understanding.
I am requesting:

☐ Meal Plan Exemption
☐ Other:

I authorize Dakota State University to receive information from my care provider in order to verify my need for a meal plan exemption. I also authorize my care provider to discuss my condition, if necessary, with appropriate Dakota State personnel.

I authorize Dakota State University to share my documentation with the Sodexo Dietitian, and I understand that I must meet with the dietitian before a decision can be made on my request.

By signing below, I affirm that all personal statements are true and accurate. I understand that falsifying or misrepresenting facts or information may result in disciplinary action.

Student Signature: _____

Date: _____

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MEDICAL PROFESSIONAL INFORMATION

Below needs to be completed by a certified medical professional.

First Name:_____Last Name:_____

Date of initial contact with student: _____

Date of last contact with student: _____

Please state the student's diagnosis(es): _____

When was the student diagnosed with the above condition(s)? _____

Please describe the dietary requirements the student must follow because of their diagnosed condition. Please provide specific examples of prescribed dietary requirements.

Please describe what type of menu options this student requires, including dietary needs or restrictions.

Is there a negative impact on the student's health if the request is not granted?

☐ No

☐ Yes (If yes, please explain)

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Certification Statement

I confirm that the information provided above is based on my professional evaluation and documentation and is, to the best of my knowledge, accurate and complete. This information should be considered when reviewing the student's request. I affirm that my assessment is not influenced by any personal relationship with the student. I understand that I may be contacted for additional information if further documentation is required.

Doctor/Health Care Provider Name (Printed): _____

Doctor/Health Care Provider (Signature):_____

Date: _____