CARROLL UNIVERSITY

Health Related Documentation
for Meal Plan Accommodation Request

(To be completed by a qualified medical doctor or specialist)
Please type or print neatly/ use a separate sheet if needed

Student Name (First, MI, Last) _____

1. What is the diagnosis? _____
2. Level of severity (if applicable)_____Mild_____Moderate_____Severe
3. When was the diagnosis made? _____
4. When was your last contact with the above named student? _____
5. Is this condition: _____Temporary -- until approximately: _____

   _____Permanent
6. Please provide a description of your patient's medical condition or symptoms:

   _____
   _____
   _____
7. Please provide any dietary or other meal plan recommendations for your patient:

   _____
   _____
   _____

Professional's Signature:_____ License #:_____

Print or type name and title: _____

Address: _____

Phone: _____ Date: _____

Direct questions to, or simply submit this form via fax, e-mail or mail to:

Dining Services
Carroll University
101 N East Ave.
Waukesha, WI 53186

Phone: 262-524-7347
Fax: 262-524-2602
Email: dining@carrollu.edu