



Meal Plan Exemption Request

For Academic Term(s) _____, 20_____

Guilford is a residential college requiring students who live on campus to eat on campus. This policy allows for few, if any, exceptions. To request an exemption, please provide the following detailed information. Please note that exemption requests are reviewed once each semester. **For fall semester, requests must be received by September 3, 2007 and applications for spring semester must be received by January 28, 2008.** Applications received after the deadline will not be considered until the next semester.

- Once documentation is received in the Office for Campus Life, an independent dietician will review the request and speak to the student's physician and/or dietician (if necessary).
- In August and January, individual appointments will be scheduled for the student to meet with the dietician, if necessary. The student will be contacted through their Guilford College email account regarding the scheduling of the appointment.
- The college's dietician will make a recommendation regarding the ability of the food service program to meet the special dietary needs of the student requesting the meal plan exemption. The recommendation may be that the food service program:
 - can meet most of the needs and will make special arrangements for those it cannot meet, in which case the student will not be exempt from the meal plan, or
 - cannot meet the special dietary needs of the student requesting the meal plan exemption in which case the student will be exempt from the meal plan and the student's total room, board, tuition and fees will be adjusted.

TO BE FILLED OUT BY THE STUDENT MAKING THE REQUEST

Student Name: (Please Print) _____ G # _____
 Home Address: _____ Home Phone: _____
 Campus Box#: _____ Campus Phone: _____

I have read and understand the meal plan exemption request policy as outlined above

Signature: _____ Date: _____

TO BE FILLED OUT BY THE PHYSICIAN

Name of Physician (please print): _____
 Address: _____
 Phone: _____ Fax: _____
 Diagnosis _____
 Date of most recent visit _____ Specific diet prescribed _____
 Any special timing of meals or food intake? _____
 Signature of Physician: _____ Date: _____

MAY BE FILLED OUT BY PHYSICIAN OR REGISTERED DIETITIAN:

Please attach any detailed schedules, diet plans or write restrictions out below. A registered dietitian may complete this section after the Physician completes the above information.

Name of RD: (please print) _____
 Address: _____
 Phone: _____ Fax: _____
 Restricted Foods: _____
 Recommended Foods: _____
 Daily Intake Requirements: _____
 Food/meal Timing Requirements: _____
 Signature of RD or MD or PA or FNP _____ Date: _____

Please return to:
 Office for Campus Life, Guilford College
 5800 W. Friendly Avenue
 Greensboro, NC 27410
 FAX: 336-316-2949

Office Use: GRANTED DENIED Approved by: _____ Date: _____

Comments: _____ Notified by email on _____