

## **Important Notes:**

All sections of this form must be completed before the request can be processed.

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- 2. If this form is not completed within 30 days of seeing your private physician, it will become invalid.
- 3. Completion of this form will initiate a professional review of your nutritional and dietary concerns. Dining Services will work with students who have dietary restrictions to ensure a medically appropriate and nutritionally sound diet.
  - After all sections of the form are completed, please scan and email to nutrition@dining.rutgers.edu. Upon review, the Dining Services Nutritionist will contact the student to discuss individual dietary needs.

I. TO BE COMP.	LETED BY THE STUD	ENT	
NAME:		ID#:	
CELL PHONE#:		EMAIL ADDRESS:	
RESIDENCE HALL:		MEAL PLAN:	
Please describe your dietary restr	ictions and any dietary adjustr	ments you require:	
			nts required. Please include when the
hysician's Signature:		Date	e:
rint Physician's Name:	Address:		
hone #:	Fax#:		
Review documentation of studen While at Rutgers, has the stu	ident eaten in places other than		when:
O Gluten free diet	O Nut free diet		·
Lactose free diet	O High Fiber diet	Other	
	ng Services Nutritionist to dete	ermine individual nutrition care	
ealthcare Provider Signature	ī	Date:	Health Center

THE HEALTHCARE PROVIDER/PHYSICIAN DOES NOT DETERMINE A RELEASE FROM THE MEAL PLAN. ALL STUDENTS RESIDING IN A RESIDENCE HALL ARE REQUIRED TO HAVE A MEAL PLAN. DINING SERVICES WILL WORK WITH STUDENTS ON AN INDIVIDUAL BASIS TO ACCOMMODATE SPECIAL DIETARY NEEDS.