3.	If the request is approved, the meal plan charge will be prorated from the date the decision was communicated.
	All charges up to that date are valid and will remain

- 4. Failure to include required documents with the Meal Plan Exemption/ Accommodation Request Form could result in a delay and/ or denial of request.
- 5. Requests based on medical condition must complete the Physicians Form.

6.

Meal Plan Exemption/Accommodation FAQ

Please review the following FAQ before submitting a request:

Q: I moved off campus, do I still need a meal plan?

A:

Meal Plan Exemption/ Accommodation Request Form Medical Department of Housing & Residential Life

GENERALINFORMATION					
Last Name:	First Name:		Student ID:		
Email:		Primary Phone: (-		
High School Graduation Year:		Current Meal Plan	n		
		Residence Hall/A	partment		
Period of Request:		Exemption Type ((check below)		
Indicate Request Period below with					
(example 2021 2022 or Fall 2021 o	. 0				
	Academic Year			Medical Exemption	
	Fall Only				
	Spring Only				
AGREEM ENT AND AUTHORIZATION					
By signing below, you acknowledge	ge you have read	the below inforn	nation and the inform	nation provided with	
this request is accurate.					
The University requires specific diagnostic information from a licensed health care provider. This physician must be familiar with the history and functional limitati The student must complete page one of the form below. To facilitate this process, the University student is required to complete and sign the Permission to Release Information. This signature allows the physician to provide information to the University, and allows the appropriate and qualified South Dakota State University staff					
completing this form. The provider must complete the pages, sign, and return the completed packet to:					
Mail: South Dakota State University Housing & Residential Life Box 2810A Caldwell Hall Brookings, SD 57007					
Student SDSU ID#: Phone Number:					
Address:					
(Street Address/PO Box	y/Residence Hall an	nd Room) /	(City)	(State/Zip)	
•		,			
I give Dr of the of the Medical Clinic/Center permission to release to South Dakota State University any and all relevant medical information needed for the medical release for which I am applying. I also authorize my physician to discuss my condition(s) with the appropriate and qualified SDSU personnel on an as needed basis.					
Student Sgnature:			Date:		
Parent/Guardian Sgnature (if studen	t is under 1 <u>8)</u>		Date:		

Explanation of Request for Meal Plan Exemption/Accommodation

3.	Is this a temporary or permanent condition? If it is tem
4.	
4.	