Charleston Culinary Group | College of Charleston
Student Meal Plan Accommodation Form
65 George St., Charleston, SC 29424 | 843.953.5538

This form is only a requirement for first-year residents who are requesting a meal plan accommodation for medical purposes.

Name: _____ **Student ID:** _____ **Date of Birth:** _____

Email: _____ **Phone:** _____

Current Meal Plan: ◯ **All Access Diamond** ◯ **All Access** ◯ **12 Meals Per Week**

What specific meal plan accommodation(s) are you requesting?

_____

_____

How would your requested accommodation(s) support you?

_____

_____

I am requesting a meal plan accommodation for the following reason:

◯ A. Medical: Please attach a letter fully describing your dietary requirements as well as the completed Provider Statement for Meal Plan Accommodation form signed by your licensed healthcare professional.

◯ B. Food Allergy: Please attach a letter fully describing your dietary requirements as well as the completed Provider Statement for Meal Plan Accommodation form signed by your licensed healthcare professional.

◯ C. Other: Please attach a letter fully describing your dietary requirements.

RELEASE OF INFORMATION REQUEST TO BE COMPLETED BY STUDENT

I hereby authorize my treating provider to discuss and release all pertinent information to the College of Charleston (Campus Services, Charleston Culinary Group, Disability Services and Residence Life) that relates to the accommodations I have requested and to establish the validity of my request. This information will be used for the express purpose of determining meal plan accommodations and will not be released to anyone else, other than the aforementioned personnel.

- I have the right to inspect and receive copies of written information to be disclosed.
- The information disclosed as a result of this consent cannot be re-disclosed by the receiving agency/facility/person to anyone not permitted by this release, unless I specifically authorize it.
- I understand that if I refuse to consent to this disclosure of information, my request will be incomplete.
- My signature indicates the statements/documentation I have provided are true and accurate.

Student Signature: _____ **Date:** _____

Please submit this form via email or in person to the Charleston Culinary Group's Registered Dietitian:
mcnair-alexandra@aramark.com or 65 George St. 843.953.5538.

Fall 2025