Medical Diet Certification By Physician

GRINNELL COLLEGE

To be completed by the student:

Student Name	Student DOB	E-mail
Campus Address	Permanent Address	Phone Number

Dietary Request:_____

To be completed by an unrelated physician:

Physician Name	Physician Address	Physician Phone

Explanation of Students Medical Condition(s) Requiring a Modified Diet
☐ Food Allergies (circle all that apply): Milk Egg Wheat Soy Fish Shellfish Peanuts Tree Nuts Other:_____
☐ Gluten Intolerance ☐ Lactose Intolerance ☐ Other Intolerance:_____
☐ Other Medical Conditions (Please specify):

What special dining arrangements are required to manage this condition?
Diet Prescription: Omitted Foods (Medically Necessary) Substitutions _____ _____ _____ _____ _____ _____ _____ _____

What is the expected duration of the dietary accommodations requested? ☐ Indefinitely ☐ Temporary (explain):_____

I certify the requested dietary accommodations are medically necessary for the above named student.

Physician Signature _____ Date _____

Please fax completed form to Grinnell Dining 641-269-4650