

**RESIDENCE HALL MEAL PLAN
EXEMPTION REQUEST
PHYSICIAN'S STATEMENT**

Student Name: _____ ID#: _____ Date: _____

Mailing Address

City, State, Zip

Phone Number

SEU email address: _____

Dear Physician:

The above named individual is a student at St. Edward's University, resides on campus and has requested to **NOT** participate in the meal plan offered to hall residents because of special dietary needs. Because of the desire to meet the student's need and the financial need of St. Edward's University to maintain the room and board package, we require medical verification from the student's physician in order to review each request.

Please complete the information below and mail completed form to:

*St. Edward's University
Attn: Director of Auxiliary Services
3001 South Congress Avenue
Austin, TX 78704-7489*

Should you require any additional information feel free to contact our office at 512.448.8605. We appreciate your assistance in this evaluation and notification in writing will be mailed to the above named student.

DIAGNOSIS:

SPECIAL DIETARY NEEDS:

Physician's Signature

Date

Physician's Printed Name

Business Address

City, State, Zip

Office Number

Fax Number