



2. Provide a detailed account of the specific diet the student is required to follow including foods the student can and cannot eat. Please feel free to attach additional sheets as needed.

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3. Describe the type, severity, and frequency of symptoms as related to the diagnosis, and how the condition interferes with the student's ability to eat in a dining hall.

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**MEDICAL/HEALTHCARE PROVIDER INFORMATION**

**THIS SECTION MUST BE COMPLETED, SIGNED OR STAMPED WITH PROVIDER'S OFFICE INFORMATION**

*The provider completing this form cannot be related to the student*

**I certify, by my signature below, that I diagnosed or am currently treating the student named above.**

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_

State of License: \_\_\_\_\_ License Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Return form DIRECTLY to: Tracy Benner, Director of Residence Life    Email: TBenner@otterbein.edu  
Fax: 614-823-3299**

**Deadline for submission is August 1 for fall semester and December 1 for spring semester.**

**This information will be shared with the Director of Dining Services and the student will be contacted to meet in person to discuss the specialized meal plan options available.**