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CHABAD HOUSE-LUBAVITCH
RUTGERS UNIVERSITY

170 College Avenue ● New Brunswick, New Jersey 08901
Tel: (732) 296-1800 ● Fax: (732) 828-6890
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***"YOUR HOME AWAY FROM HOME"***

# MEAL PLAN MEDICAL & DIETARY CONSIDERATIONS

1. All sections of this form must be completed before the request can be considered and processed.
2. Completion of this form will initiate a review of your nutritional and dietary concerns. Dining Services will work with students who have special dietary needs to ensure a medically appropriate and nutritionally sound diet based on our menu and make adjustments accordingly.
3. After all sections of the form are completed, please return it to the main office on 170 College Avenue, 2nd Floor. It will then be forwarded to Dining Services who will contact the student to discuss individual dietary needs
4. Please fill out the emergency form and consents on the reverse side of this form.

| **I. TO BE COMPLETED BY THE STUDENT** | | |
|---|---|---|
| Name: | | Rutgers ID: |
| Cell #: | Email Address: | |
| Academic Year: | | Meal Plan: |

Please describe and/or list medical conditions, prescription medications, and/or dietary needs and any adjustments you require:

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| **II. TO BE COMPLETED BY PRIVATE PHYSICIAN OR RUTGERS HEALTHCARE PROVIDER.** | | |
|---|---|---|
| Describe briefly your medical findings regarding the student's condition or special dietary adjustments required. If needed, please attach an emergency treatment plan. | | |
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| Please list any current medications student is currently taking: | | |
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| Please suggest dining/nutritional accommodations to be considered for this student: | | |
| ☐ Gluten free diet | ☐ Nut free diet | ☐ Special ingredient diet_____ |
| ☐ Lactose free diet | ☐ High Fiber diet | ☐ Other_____ |
| Hospital of preference in the event of an emergency: _____ | | |
| Print Provider's Name: | | Address: |
| Phone #: | | Fax #: |
| Provider's Signature: | | Date: |

THE PHYSICIAN/HEALTHCARE PROVIDER DOES NOT DETERMINE A RELEASE FROM THE MEAL PLAN OBLIGATION. ALL STUDENTS RESIDING IN CHABAD HOUSE OR ANY OTHER RUTGERS RESIDENCE HALL ARE REQUIRED TO HAVE A MEAL PLAN. DINING SERVICES WILL WORK WITH STUDENTS ON AN INDIVIDUAL BASIS TO ACCOMMODATE SPECIAL DIETARY NEEDS.

Student's Signature:_____

## Emergency Contact and Consent

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|---|---|
| Student's Name: | Birth date: |
| Home Phone: | Cell Phone: |
| Address: | |
| Mother's Name | |
| Work Phone: | Cell Phone: |
| Father's Name: | |
| Work Phone: | Cell Phone: |

## Please list two additional Emergency Contacts:

| | |
|---|---|
| Name: | Daytime Phone: |
| Relationship: | Cell Phone: |
| Name: | Daytime Phone: |
| Relationship: | Cell Phone: |
| Name and phone number of primary care physician: | |

## Authorization to Obtain Urgent or Emergency Medical Care

I, _____ (name of student), give permission for Chabad House at Rutgers and its staff, to provide or obtain urgent emergency medical care on my behalf for my own benefit. I authorize health care providers to render such care as may be necessary. I agree to be financially responsible for such care.

| | |
|---|---|
| Student Name (Print below): | Student Signature: |
| Medical Insurance Company: | Policy/Group Number: |
| Participant ID Number: | Insurance Phone Number: |

## Photo Permission

I understand that I may be included in photographs and video footage that may be filmed at Chabad House. I authorize Chabad House at Rutgers to use these photos/videos to promote its programs and services in print, web, and other promotional contexts.

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|---|---|
| Student Name (Print below): | Student Signature: |