HOPKINS COUNTY SCHOOLS MEAL ACCOMODATIONS FORM

PART A: TO BE COMPLETED BY A PARENT/GUARDIAN.	
Student Name:	**Date of Birth:**
School:	**Grade Level:**
Today's Date:	
PART B: TO BE COMPLETED BY A HEALTHCARE PROVIDER. (Medical Doctor-MS, Osteopath-OD, Advanced Registered Nurse Practioner-ARNP, or Physician Assistant-PA)	
Diagnosis:	
List any dietary restrictions or special diets.	
List any allergies or food intolerances to avoid.	
Recommended food alterations for allergies/intolerances listed above.	
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "ALL". **Cup up/chopped:** **Finely ground:** **Pureed:**	
Indicate any other comments about the child's earting, feeding patterns, or feeding techniques.	
Parent/Guardian Name (Print):	**Signature/Date:**
Heathcare Provider Name (Print):	**Signature/Date:**
Healthcare Provider Office Address:	
Healthcare Provider Office Number:	**Healthcare Provider Fax Number:**
TO BE COMPLETED BY PARENT/GUARDIAN:	
Reviewed By:	**Date:**
Reviewed By:	**Date:**
Reviewed By:	**Date:**