GRAVES COUNTY SCHOOL MEAL ACCOMMODATIONS FORM

PART A: TO BE COMPLETED BY A PARENT/GUARDIAN.		
Student Name:	**Date of Birth:**	**Grade Level:**
School:	**Today's Date:**	
PART B: TO BE COMPLETED BY A HEALTHCARE PROVIDER. (Medical Doctor- MS, Osteopath-OD, Advanced Registered Nurse Practitioner- 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". **Cut up/chopped:** **Finely ground:** **Pureed:**		
Indicate any other comments about the child's eating, feeding patterns or feeding techniques.		
Parent/Guardian Name (Print):	**Signature:**	**Date:**
Healthcare 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:**	