HOPKINS COUNTY SCHOOLS MEAL ACCOMMODATIONS FORM
2023-2024

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 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". Cup 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: