

GRAVES COUNTY SCHOOLS 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:		
How does the diagnosis impact daily life?		
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:	

[THE KENTUCKY PUBLIC SCHOOL DISTRICT SECTION 504 PARENT RIGHTS STATEMENT](#)

[USDA NONDISCRIMINATION STATEMENT](#)