WEBSTER COUNTY SCHOOL MEAL ACCOMMODATION FORM

Part A: To be completed by a Parent/Guardian	
Student Name:	**Date of birth:**
School & Grade:	**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 Address and Office Phone Number:	
Reviewed by:	**Date:**
Reviewed by:	**Date:**