Fulton County Schools
Where Students Come First

Student Health Services

Dietary Care Plan

Completion of this Dietary Care Plan authorizes Student Health Services and School Nutrition to discuss the dietary order/request with the prescribing health care provider if indicated and/or needed via email, verbal, fax, or written communication with the purpose of providing a safe environment for your student.

Student's Name _____D.O.B_____Teacher_____
School_____ Grade_____ (****Please attach picture to Care Plan)***

***Diagnosis**: _____ **Food Allergy or Food Intolerance to**: _____*

☐ ***Box checked indicates student does not require special meals by School Nutrition.***

☐ ***Box checked indicates student has a severe food allergy which may lead to anaphylaxis and will require food substitutions.***

☐ ***Box checked indicates student has a chronic condition or metabolic disorder and will require food substitutions.***

☐ ***Box checked indicates student has a current 504 or IEP including this disability with dietary modifications noted.***

****If food substitutions are required the information will be documented below.***

Fulton County School Nutrition Program cannot guarantee that food products served in school cafeterias were not processed in plants that also process nut products.

Dietary Restrictions/Special Diet. Foods to be omitted: _____
_____
_____
_____

Food Substitutions for Food Allergy/Food Intolerance/Disability: _____
_____
_____
_____

Do any foods require texture modifications? □ Yes □ No If yes, list change type and foods below.
Change type: □ Bite Sized Pieces □ Finely Ground □ Pureed
If yes, list foods: _____
_____
_____

Are special food supplements or substitutions required? _____
_____

Any other information regarding student's eating or feeding patterns? _____
_____

Does this student have a Food Allergy Care Plan on file in the school clinic? □ Yes □ No *If yes attach a copy
Does this student have an Epipen or Antihistamine in the school clinic? □ Yes □ No □ Carries medication
Is the student asthmatic □ Yes* □ No *Does this student have an Inhaler at school? □ Yes □ No □ Carries medication
****Higher risk of severe reaction Yes or No – please circle***

In Case of an Allergic Reaction/Emergency

1. Notify Administration and the School Clinic. *Emergency medications if available will be administered.*
2. Call 911 if unresponsive or Epipen given. Begin the steps of CPR if unresponsive and get the AED if one is available.
3. Dr's full name: _____ Office Phone: _____
4. Emergency contacts: Name/Relationship Phone Number(s)

a. _____1._____ 2. _____
b. _____1._____ 2. _____
c. _____1._____ 2. _____

Parent/Guardian Signature_____Date_____
Physician's Name (*print legibly*) _____Signature_____Date_____

Received Date SHS: _____Cluster Nurse/Special Education Nurse Signature_____
Date sent to School Nutrition_____

SHS/SN 11-09