



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