Fulton County Schools
Meal Accommodations Form

Part A: TO BE COMPLETED BY A PARENT/GUARDIAN		
Student's 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:
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):	Healthcare Provider Name (PRINT):
Parent/Guardian Signature:	Healthcare Provider Signature:
Date:	Date:
Parent/Guardian's Home Address:	Healthcare Provider's Office Address:
Parent/Guardian's Phone Number	Healthcare Provider's Office Number:
	Healthcare Provider's Fax Number:

PART C: TO BE COMPLETED BY FOOD SERVICE DEPARTMENT:	
Reviewed By:	Date:
Reviewed By:	Date:
Reviewed By:	Date: