Discontinuation of Site Meal Modifications

If your student no longer requires meal accommodations, please fill out the form below. To be completed by a physician/medical authority or parent/legal guardian.

Licensed Physician/Medical Authority Name ____________________________________________
OR
Parent Name ______________________________________________________________________

Student Name ______________________________________________________________________

Site ______________________________________________________________________________

I certify that the student named above is no longer in need of the previously prescribed meal modifications effective on the following date: ________________________________

Signature of Licensed Physician/Medical Authority ____________________________
Licensed Physician/Medical Authority’s Title ____________________________

OR

Signature of Parent ____________________________________________________________

Street Address ____________________________ Date ____________________________

This institution is an equal opportunity provider.