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.