Discontinuation of Meal Modifications Prescribed by a Medical Authority

Medical Authority's Name _____

Student's/Participant's Name _____

School/Facility _____

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

____ ______
Signature of Medical Authority Date

______
Street Address

______
Phone

______
City, State, Zip

Discontinuation of Substitution for Fluid Cow's Milk Requested by a Parent/Guardian

Name of Student/Participant _____

School/Facility _____

I certify that the student/participant named above is no longer in need of the previously requested substitution for fluid cow's milk effective on the following date: _____

____ ______
Signature of Parent/Guardian Date

______
Street Address

______
Phone

______
City, State, Zip

This institution is an equal opportunity provider.