

## 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

\_\_\_\_\_