Discontinuation of School Meal Modifications Prescribed by a Medical Authority

Medical Authority's Name	
Student's Name	
School	
	o longer in need of the previously prescribed meal
modifications effective on the following dat	e:
Signature of Medical Authority	 Date
Signature of Medical Admonty	Date
Street Address	Phone
City, State, Zip	
	bstitution for Fluid Cow's Milk by a Parent/Guardian
School	
I certify that the student named above is no	o longer in need of the previously requested the following date:
Signature of Parent/Guardian	Date
Street Address	Phone
City, State, Zip	