Discontinuation of School Meal Modifications Prescribed by a Medical Authority

Medical Authority's Name _____

Student's Name _____

School _____

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 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 _____

School _____

I certify that the student 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