

**Discontinuation of School Meal Modifications
Prescribed by a Licensed Physician or Medical Authority**

Licensed Physician/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 Licensed Physician/Medical Authority

Licensed Physician/Medical Authority's Title

Street Address

Date

City, State, Zip

Phone

**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