

**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

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