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

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