Discontinuation of Diet Instructions for Allergies, Intolerances or Disabilities

Name of Medical Authority: ____

Name of Student: ____

School: ____

I certify that the student named above is no longer in need of special school meals effective on the following date: ______________________________.

____ ______________
Signature of Recognized Medical Authority Date

____ ______________
Street Address Phone Number

____
City, State, Zip

____ ______________
Parent/Guardian Signature Date

Parent/Guardian

I give ______________________ school's personnel permission to contact the medical
(Name of School)
authority named above in order to clarify dietary needs for my child.

____ ______________
Parent/Guardian Signature Date

____ ______________
Street Address, City, State, Zip Phone Number

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