

# 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

I give \_\_\_\_\_ School's personnel permission to  
(Name of School)

contact the medical authority named above in order to clarify dietary needs for my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Street Address, City, State, Zip

\_\_\_\_\_  
Phone Number