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

This institution is an equal opportunity provider.

COLORADO Department of Education