Discontinuation of Meal Modifications Prescribed by a Medical Authority

Medical Authority's Name _____

Student's/Participant's Name _____

School/Facility _____

I certify that the student/participant named above is no longer in need of the previously prescribed meal modifications effective on the following date: _____

_____ _____

Signature of Medical Authority Date

_____ _____

Street Address Phone

_____

City, State, Zip

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(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.