

## 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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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (in Spanish).