



**Food & Nutrition Services**

Salina Public Schools

**Discontinuation of Meal Modification**

Student's Name \_\_\_\_\_

School \_\_\_\_\_

I certify that the student named above is no longer in need of the previously prescribed meal modification effective on the date of this form.

\_\_\_\_\_  
Printed Name of Parent/Guardian OR Medical Authority

\_\_\_\_\_  
Signature of Parent/Guardian OR Medical Authority

\_\_\_\_\_  
Date

This institution is an equal opportunity provider.