Discontinuation of Modified Meal Modifications

If your student no longer requires meal accommodations, please fill out the form below.
To be completed by a physician/medical authority or parent/legal guardian.

Licensed Physician/Medical Authority Name ____
OR
Parent Name ____

Student Name ____

Site ____

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

OR

____
Signature of Parent

____	______________________________
Street Address	Date
____	______________________________

This institution is an equal opportunity provider.

July 2017

COLORADO
Department of Education