

**Lewiston-Porter Central School District**  
**4061 Creek Road, Youngstown, NY 14174**  
**(716) 754-8281 ; (716) 286- 7876 Fax**

2026

5661F1

Non-Instructional/Business Operations

**Discontinuation of Special Dietary Accommodations for Meal Modifications**

We are committed to serving our students nutritious meals each day, including those students who require meal modifications to meet medically diagnosed or special dietary needs. To help us better meet the dietary needs of all students, it is important that we be notified as soon as possible of any changes to the students' special dietary needs. Please complete this form and return it to the nurse at your child's school. A copy will be given to our Food Service Manager to make the necessary changes.

**Note: A Physician's signature is required on this form.**

|                                                                                                      |                                |
|------------------------------------------------------------------------------------------------------|--------------------------------|
| <b>Completed by Parent/Guardian:</b>                                                                 |                                |
| Student Name: _____                                                                                  | Student ID: _____              |
| School Name: _____                                                                                   | Grade: _____ HR Teacher: _____ |
| <input type="checkbox"/> Discontinue current meal modification/request                               |                                |
| <input type="checkbox"/> Discontinue part of current meal modification/request                       |                                |
| If discontinuing part of the current meal modification, please indicate the modification to be made: |                                |
| <input type="checkbox"/> No longer allergic to: _____                                                |                                |
| <input type="checkbox"/> Other, please describe: _____                                               |                                |
| _____                                                                                                |                                |
| Physician Signature: _____                                                                           |                                |
| Physician Name: (print) _____                                                                        | Date: _____                    |
| Physician Office Phone No.: _____ Office Contact Person: _____                                       |                                |

|                                                                            |
|----------------------------------------------------------------------------|
| <b>School/District Office Use Only</b>                                     |
| Date Form Received: _____                                                  |
| Date Changed: _____                                                        |
| Food Service Manager Signature: _____                                      |
| Copies of this form are kept by the School Nurse and Food Service Manager. |

|                                                    |
|----------------------------------------------------|
| This Institution is an equal opportunity provider. |
|----------------------------------------------------|