Discontinuation of Meal Modification Requests
School Year 2026-2027

In order to better serve our children, it is important to notify us as soon as possible of any changes to the student's special dietary needs. Please complete this form and return it to the Food Service Manager at your child's school site in order for us to make any menu changes. (We do not need a physician's signature for this form.)

Must be completed by the Parent/Guardian

County: _____

School District: _____

Name of Student _____ Student's ID _____ Grade: _____
School Name: _____ Teacher's Name: _____

Select: ☐ **Discontinuation of current diet prescription/request**
☐ **Discontinuation of part of current diet prescription**

If discontinuation of part of current diet prescription is selected, please indicate the modification needed:

☐ **No longer allergic to: _____**
☐ **Other, please describe _____**
_____

Parent/ Guardian Signature: _____ Daytime Phone Number: _____
Email Address: _____ Date: _____

For School Use only
Date form received _____
Date alert changed _____
Manager's Signature _____
(Please maintain a copy of this form on file and provide a copy to the school nurse, registered dietitian, and/or other school staff as directed by program policies.)