

Dietary Accommodations Discontinuation

All sections must be **completely** filled out for this form to be accepted.

School Year: _____

A. THIS SECTION TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

Student Name (Last, First): _____ Date of Birth: ____/____/____
Campus: _____ Grade: _____ Student ID: _____
Parent/Guardian Name (please print): _____ Phone: _____
Email Address: _____
Signature: _____ Date: _____

B. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN

Previously prescribed dietary accommodations: _____

All dietary accommodations listed above will be discontinued and removed from students account.

Clinic/ Facility Name: _____ Phone: _____
Address: _____
Physician Name (please print): _____ Date: _____
Physician Signature: _____

For questions about this form please contact LCISD Dietitian: Kaisha Martelly Molinar. Phone: 832-223-0188, Fax 832-223-0187 or email kaisha.molinar@lcisd.org

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