

## 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 or email kaisha.molinar@lcisd.org*

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