LAMAR CISD
A PROUD TRADITION | A BRIGHT FUTURE

LCISD
Child Nutrition Department

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