PARENTAL REQUEST FOR A FLUID MILK SUBSTITUTION FOR SCHOOL-AGE CHILDREN

1. NAME OF STUDENT	**2.** AGE OR DATE OF BIRTH
3. NAME OF PARENT/LEGAL GUARDIAN	**4.** TELEPHONE NUMBER ( )

5. EMAIL ADDRESS:

6. The above listed student does not have a disability, but is requesting a fluid milk substitute due to a medical or other special dietary need. This form is not intended to accommodate students who do not drink cow's milk due to taste or other preferences. This written statement will remain in effect until the parent or legal guardian revokes such statement or until the school discontinues the fluid milk substitution option. School districts and agencies participating in federal nutrition programs are encouraged, but not required, to accommodate reasonable requests. **The student's parent or legal guardian must sign this form. Medical authority signature is optional.**

7. MEDICAL OR OTHER SPECIAL DIETARY NEED REQUIRING A FLUID MILK SUBSTITUTION:

( ) LACTOSE INTOLERANCE
( ) NON-LIFE-THREATENING MILK ALLERGY
( ) RELIGIOUS, ETHNIC, CULTURAL BELIEF

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO THE STUDENT:

( ) Student who avoids fluid milk only
( ) Student who avoids fluid milk AND dairy products (cheese and yogurt)
( ) Student who avoids milk as an ingredient in all food products (milk allergy)

8. REQUESTED FLUID MILK SUBSTITUTE (PLEASE NOTE THAT THE SCHOOL FOOD AUTHORITY HAS THE DISCRETION TO SELECT A SPECIFIC BRAND WHICH MEETS SPECIFIC NUTRITIONAL CONTENT)*:

( ) LACTAID
( ) DISTRICT APPROVED SOY MILK SUBSTITUTE
( ) NO SUB REQUESTED

*School districts, by regulation, are not permitted to substitute juice or water in place of fluid milk for non-disabling conditions.

9. SIGNATURE OF PARENT/LEGAL GUARDIAN	PRINTED NAME OF PARENT/GUARDIAN	DATE
10. SIGNATURE OF MEDICAL AUTHORITY (OPTIONAL)	PRINTED NAME OF MEDICAL AUTHORITY	DATE

OFFICE USE ONLY

The information on this form should be updated annually to reflect the current medical and/or nutritional needs of the student.

Date:	Status:
Date:	Status:

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