MILK SUBSTITUTION FORM

School Year:

Does the student have a milk (disability) allergy requiring a milk substitution other than lactose free milk? (Check one)
☐ Yes ☐ No

If **Yes**: A **Qualified Medical Authority*,** must complete Part I of this form.
If **No:** A parent/guardian may complete student information and Part II of this form to request a milk substitution.

Student's Name:_____ DOB:_____ School: _____ Grade:____

Parent/Guardian Name: _____

Phone:_____ E-mail:_____

Part I: For Qualified Medical Authority to Complete (Only complete this if child has a disability/medical need/ impairment) *A qualified medical authority is a medical professional who has prescriptive privileges in the state of Indiana.

Student's Disability/medical need/impairment (explain):_____

How does the impairment listed above restrict his/her diet? (explain):_____

Major life activity affected by the student's disability: _____

Omitted Beverage(s)*	Allowed Substitution(s)

Additional Comments:
_____

I certify that the above named student needs a milk substitution due to a disability/ medical need/ impairment.

_____

_____ _____ _____ _____
Medical Authority Signature | Medical Authority Printed Name | Office Phone Number | Date

Part II: For Parent/Guardian who request a milk substitution that is simply lactose-free (and has a nutritional profile equivalent to cow's milk).

Please explain why your child needs a milk replacement that is lactose-free.
_____

Parent/Guardian's Additional Comments**:**_____
_____

I give Health Services/Nursing/Nutrition Services permission to speak with the Health Care Provider above to discuss my child's special dietary needs, if applicable..

_____ _____
Parent/Guardian's Signature Date

PLEASE RETURN COMPLETED FORM TO YOUR SCHOOL NURSE

Modified 4/30/2018