## 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 <b>Yes</b> : A <b>Qualified Medical Authority*</b> , must complete Part I of this form.  If <b>No:</b> A parent/guardian may complete student information and Part II of this form to request a milk substitution.				
Student's Name:	DOB	3: School	<b>:</b>	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				
Pa	arent/Guardian's Signa	ture Date		

PLEASE RETURN COMPLETED FORM TO YOUR SCHOOL NURSE