MILK SUBSTITUTION FORM

2020-2021

Does the student have a milk allergy (disability) requiring a milk substitution other than a lactose-free milk substitute nutritionally equivalent to cow's milk? (Check one)

☐ Yes ☐ No

If Yes: A Qualified Medical Authority*, also must complete Part II of this form.

General Information:

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

Parent/Guardian Name:

_____

Phone:_____ E-mail:_____

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

_____

Additional Comments:_____

Part II: For Qualified Medical Authority* to Complete (Only complete this if child has a disability, medical need, and/or impairment)

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

***A qualified medical authority is a medical professional who has prescriptive privileges in the state of Indiana.**

Signing the following section is optional, but may prevent delays by allowing school personnel to speak with the medical authority.

Health Insurance Portability and Accountability Act Waiver (HIPPA)

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and Family Educational Rights and Privacy Act (FERPA), I hereby authorize _____(medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____(school/program), and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, with the SCHOOL PROGRAM as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent/guardian/or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature:_____ Date:_____

PLEASE RETURN YOUR COMPLETED FORM TO Amber Swinehart, Director of Nutrition & Food Services .

This institution is an equal opportunity provider.

Modified 7/20/2018