Parent/Guardian Request for Milk Substitute

Center: _____ ☐ Early Head Start ☐ Head Start ☐ ECEAP

Child's Name: _____DOB: _____Gender: M / F

Requesting a Milk Substitute

If your child cannot drink regular cow's milk, your child may be provided a substitution when milk is served at meals. The substitutions allowed by the Washington State Child and Adult Care Food Program are nutritionally equal to cow's milk.

1. Please tell us why your child needs a milk substitute: _____
   _____
   _____

2. Please select which milk substitute(s) that your child can consume:
   - ☐ 1% or Fat Free Lactose-Free Cow's Milk
   - ☐ USDA Approved Soy Milk*
     *8th Continent, Pacific Ultra Soy (Original), Great Value (Original), Kirkland Organic Soymilk (Plain) , Silk Original
   - ☐ Whole Milk Lactose-Free Cow's Milk (child 12-24 months old only)
   - ☐ None of the above: Please complete step 3 below.

3. My child cannot consume the above substitutions due to a: (choose one)
   - ☐ Personal Preference: EHS/Head Start/ECEAP is not required to provide milk substitutions for personal preference. I can provide my child's milk substitution within the guidelines of the classroom's family-style meal practices. Completion of the *Child Supplemental Food Plan Food Allergies/Intolerances/Food Preferences Form* is needed.
     List substitution: _____
   - ☐ Medical Condition: Completion of the *Child Health Plan and Provider Orders - Dietary Accommodations Food Allergies / Intolerances* form is required to obtain and serve the prescribed substitute(s).

Parent/Guardian Signature Date