Dear Parent or Guardian,

Thank you!

If your child is unable to drink milk due to a medical or special dietary need, the Food Service Department is offering to provide a milk substitute with School Breakfast and Lunch.

Because the substitute must meet specific USDA guidelines, the product will be White, Fat Free Lactose-Free Milk (Lactaid®). No other substitution will be provided.

If you would like to request that your child receive this substitution, please complete and return the form below and send it to the school cafeteria or the Food Service Office at 220 Ewingville Rd., Ewing, NJ 08638. The form must be completed in its entirety, including the medical or special dietary reason for the request. A doctor's note is no longer necessary.

If you have questions, you may call the Food Service Office at (609)538-9800 x7106 or e-mail drevayshaw@ewingboe.org.

Debra Revay Shaw Dietitian		
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MILK SUBSTITUTION REQUEST		
My child,cannot drink milk due to the following me	, a student atedical or special dietary need:	School
I am requesting that my child receive a se School Breakfast or Lunch Program. I un Free, White Lactose Free Milk (Lactaid®).	derstand that the substitution provide	
Signature:	Date:	
Parent's Name:		
Parent's Phone #:	E-mail	
Kindly discuss this with your child to be so Fat Free Lactaid® before making this req		e and drink the
The school cafeteria will try to have suffice students whose parent/guardian has required with this by providing the following info	uested that they receive it. We ask t	
On average, how many days per week do cafeteria with Lactaid®?		kfast in the
On average, how many days per week do cafeteria with Lactaid®?		h in the
Please return this form to the school cafe.	eteria or Food Service Office.	