Request to Substitute Fluid Cow's Milk
2026-2027

Student Name: _____ District: _____

Birth Date: _____ School: _____

Parent Name: _____ School Contact: _____

Address: _____ School Address: _____

Phone: _____ School Phone: _____

To be completed by a recognized medical authority such as a physician, physician's assistant, nurse practitioner OR by a parent/guardian.

The school is not required to provide substitutions for a milk allergy, lactose intolerance, or for any other non-medical reason, and is permitted to do so **only** when omitted foods and appropriate substitutions are specified by a recognized medical authority or parent/guardian. If diet modifications are implemented by the school, they will continue until either a recognized medical authority or a parent/guardian specifies that they should be changed or stopped. Parents/guardians are encouraged to annually provide updated instructions for diet modifications from a recognized medical authority or a parent/guardian.

Dietary Accommodations: Select one.

☐ **Lactose Intolerance – Please offer student:**
- ☐ Lactose-free milk
- ☐ Milk substitute approved by USDA

OR

☐ **Milk allergy – Instead of fluid cow's milk, please offer student:**
- ☐ Milk substitute approved by USDA (Use Form 21-E to list specific omissions and substitutions)

OR

☐ **Religious, ethical or cultural reasons – Instead of fluid cow's milk, please offer student:**
- ☐ Milk substitute approved by USDA

Certification:

I certify that the student named on this form needs the prescribed fluid cow's milk omission and substitution(s) due to his/her milk allergy or lactose intolerance(s).

_____ _____ _____
Medical Authority's Signature | Phone Number | Date

OR

I hereby give permission for the school staff to omit fluid cow's milk and make the above identified substitution(s) in my child's school meals.

_____ _____ _____
Parent/Guardian's Signature | Phone Number | Date

This institution is an equal opportunity provider.