Milk Substitute Request
Non-Disabled Students With Medical or Other Special Dietary Needs

Part I To be competed by School District or Parent/Guardian

Name of Student: _____

School District: _____

School Name: _____

Part II Substitution

List food to be omitted from diet:

_____Fluid Milk_____

_____

List food to be substituted:

_____Nutritional equivalent milk substitute_____

_____

Medical or other dietary need for substitution:

_____

_____

_____

Name of Parent/Guardian (Print Clearly)

_____

Signature of Parent/Guardian

Date _____