Milk Substitute Request
Participants without Disabilities

Part I To be completed by Sponsor, Parent/Guardian or Adult Participant

Name of Participant: _____

Part II Substitution

To be completed by the Parent/Guardian or Adult Participant or a State licensed health care professional who is authorized to write medical prescriptions under State law* or a Registered Nurse (RN) or a Registered Dietitian (RD).

List food to be omitted from diet:

__Fluid Milk_____

_____

List food to be substituted:

_Nutritionally Equivalent Milk Substitute_____

_____

Medical or other dietary need for substitution:

_____

_____

_____

Name of Parent/Guardian, Adult Participant or State licensed health care professional (Print Clearly)

_____

Signature of Parent/Guardian, Adult Participant or State licensed health care professional

Date _____

*Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified nurse practitioner or clinical nurse specialist; Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD)

This institution is an equal opportunity provider.

December 2015