

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

**Part I** To be completed by School District or Parent/Guardian

Name of Student: _____
School District: _____
School Name: _____

**Part II** Substitution

List food to be omitted from diet: _____ <u>Fluid Milk</u> _____ _____
List food to be substituted: _____ <u>Nutritional equivalent milk substitute</u> _____ _____
Medical or other dietary need for substitution: _____ _____

_____ Name of Parent/Guardian (Print Clearly)
_____ Signature of Parent/Guardian
Date _____