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 __________________________