Milk Substitute Request
Participants without Disabilities

Part 1 To be completed by Sponsor, Parent/Guardian or Adult Participant

Name of Participant:______________________________

Child Care Provider/Facility:______________________________

Part 2 Substitution

To be completed by the Parent/Guardian, Adult Participant or one of the following recognized medical authorities: Medical Doctors (MD), Doctor of Osteopathy (D)), Physician's Assistants (PA), Registered Dietitians (RA), Nurse Practitioners (NP), Registered Nurses (RN), Naturopathic Physician (ND), and Naturopathic Doctor of Osteopathy (NDO)

List food to be omitted from diet:

____Fluid Milk______________________________

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Check food to be substituted (Nutritionally Equivalent Milk Substitute):

- ☐ 8th Continent Soy Milk (plain)
- ☐ Pacific Soy Ultra (plain)
- ☐ Sunrich Natural Organic Soy Milk (plain)
- ☐ Kirkland Organic Soy Milk (plain & original)
- ☐ Walmart Great Value Soy Milk (original)
- ☐ Silk Original Soy Milk (original only)

Medical or other dietary need for substitution:

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Name of Parent/Guardian, Adult Participant or Recognized Medical Authority (Print Clearly)

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Signature of Parent/Guardian, Adult Participant or Recognized Medical Authority

Date ______________________________

"This institution is an equal opportunity provider"