Milk Substitute Request Non-Disabled Participants with Medical or Other Special Dietary Needs in Child Nutrition Programs

Part I To be completed by Sponsor or Parent/Guardian

Name of Participant:					
Sponsor:					
Site/Provider:					
Part II Substitution					
List food to be omitted from diet:					
Fluid Milk					
List food to be substituted:					
Nutritionally Equivalent Milk Substitute – Enter Product Name Here					
Medical or other dietary need for substitution:					
Name of Parent/Guardian (Print Clearly)					
Signature of Parent/Guardian					
Date					

USDA and this institution are equal opportunity providers and employers.

Milk Substitute Request

Non-Dairy Beverage Substitutes Determined to Meet the Standard for Fluid Milk by ODE CNP*

- 8th Continent Soy Milk (plain and vanilla)
- Pacific Soy Ultra (plain and vanilla)
- Kikkoman Pearl Smart Organic Soy Milk, 8.25 ounce individual pack only (Smart Creamy Vanilla and Smart Chocolate)
- Kirkland Organic Soymilk (plain)
- Walmart Great Value Soymilk (original)

OMC	- SEVERE ALLERGY AND		ON PROTOCOL			
Child's Name: SEQU	hild's Name: SEQUOYA BERRY Date of Birth: 1/12/11					
Provider Name:			Telephone			
Has child ever seen a physic	cian for allergy concerns? If so, p	lease explain: 45	SIWAS ABUT TO			
			s the diagnosis and when was it made?			
COULD NOT B	IAGNOST W/ OUT	Ment TT	Stra			
Has child ever been hospital	ized for a severe allergic reaction	i? Yes ☐ No ☒ If "Ye	s" please explain:			
EMERGENCY ACTION is no	ecessary when child has symptor	ns such as: NON	F			
g						
MEDICATIONS :		10 TT 40 T				
MEDICATIONS should be ad	dministered by Head Start staff w	hen: 10000				
Give MEDICATIONS as follows:	ows: Method of Administration		Francisco (III Miles			
Name of Medication	Method of Administration	Dosage	Frequency of Use-When to use			
Check for possible side effect	te such as: N/A					
Official for possible side effect	is such as. r /r					
IF CHILD SHOWS ANY	SIGNS OR SYMPTOMS (OF ANAPHYLAXI	S STAFF MUST CALL 911			
AND INITIATE THE EM	ERGENCY MEDICAL RES	PONSE SYSTEM	AS WELL AS CONTACT THE			
CHILD'S PARENTS.						
_						
For purposes of this protocol	"severe allergy" refers to any alle	ergic reaction where e	xposure to the allergen or causative			
as tightness of chest or throa	at breathing difficulty wheezing	sction where symptom swollen or blue line, s	ns of "Anaphylaxis" are present, such wollen tongue or throat, hives or rash,			
shall be considered "life threa	atening".	swoller or blue lips, s	wollen longue of throat, filves of fash,			
Special Instructions: NOM	5					
		Tribute and the second of the	70			
I request and authorize this E	MERGENCY PROTOCOL to be	followed for the period	d commencing with the 77 day			
such protocol necessary. In:	all cases emergency protocol for	nere exists a valid her	alth reason which makes enacting			
	an cases emergency protocor for	allergy strail be review	**			
Physician Signature:			Date:			
Parent Signature:	Toky		Date: 10/24/19 Id's physician and in accordance with the time			
frames listed above, not to exceed or	MCHS staff to enact the emergency proc ne year.)	edures identified by my chi	ld's physician and in accordance with the time			
	MEDICAL STATEMENT FO	R FOOD SUBSTITUT	IONS			
Medication Condition that req	uires child to have Food Substitu	tion(s): 1 ACTOSE	- INTOLERANT			
Food to be Omitted:		Pagammandad Fa	ad Cubatitutian.			
Fluin cow	SMILK	Recommended Food Substitution:				
I certify that the above named	child requires the food substituti	ons(s) as described for	or medical reasons:			
Print Name and Title:		227 W				
Recognized Medical Authority (A "Recognized Medical Authority	/ Signature:	n'e Accietante (DA) Decist	Date:			
Registered Nurses (RN),	Naturopathic Physician (NP), Doctor of O	isteopathy (DO), and Natur	opathic Doctor of Osteonathy (NDO)			

Child/Family Advocates are responsible for ensuring substitute staff are informed of procedures outlined within this allergy and food substitution protocol.

Maintain completed original in Center File with copies to Emergency Contact Binder and HSD.

DEC 08 7111

UMC	- SEVERE ALLERGY AND		N PROTOCOL
Child's Name: HUYAWA	(To Be Completed by Chil	o s Parent and Physician)	ate of Birth: () 7/04/07
Provider Name:		T	elephone: 54 L-
Has child ever seen a physici	an for allergy concerns? If so, p	please explain: Y65_	A PRESCRIPTION
Has allergy been "diagnosed"		o⊠Jf "Yes", what was t	he diagnosis and when was it made?
	zed for a severe allergic reaction		please explain:
EMERGENCY ACTION is ne	cessary when child has symptor	ms such as:	
	CHF, HURTFUL 6		BLOATING J
	INT WATER PER	UBBGO STUMPE	At to REVENT
BLOGGING / 9AB		1 1	
MEDICATIONS should be ad	ministered by Head Start staff w	/nen: 10010 F	
Give MEDICATIONS as follo			
Name of Medication	Method of Administration	Dosage	Frequency of Use-When to use
/			
Check for possible side effect	s such as: Stomacht T	AINS BLER	AFRESORIO + ANTH
0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			1
IF CHILD SHOWS ANY	SIGNS OR SYMPTOMS	OF ANAPHYLAXIS	STAFF MUST CALL 911
AND INITIATE THE EMI	ERGENCY MEDICAL RES	SPONSE SYSTEM	AS WELL AS CONTACT THE
CHILD'S PARENTS.			
For purposes of this protocol '	'severe allergy" refers to any all	ergic reaction where ex	posure to the allergen or causative
agent is know to be or may be	ecome "life threatening". Any re	action where symptoms	of "Anaphylaxis" are present, such
		swollen or blue lips, sw	ollen tongue or throat, hives or rash,
shall be considered "life threa	tening .		
Special Instructions: 1445	NEVER HAPPEN	60	
eposial motiones.			
			77
I request and authorize this E	MERGENCY PROTOCOL to be	followed for the period	commencing with the 7 + day
of 0, 20, 19, through the		there exists a valid hea	Ith reason which makes enacting
The second secon	all cases emergency protocol for		
Physician Signature:		1	Date:
Parent Signature:	en Buy		Date: 10/77/14 's physician and in accordance with the time
(My signature signifies consent for UI	MCHS staff to enact the emergency pro	cedures identified by my child	's physician and in accordance with the time
frames listed above, not to exceed or	ie year.)		
	MEDICAL STATEMENT FO	R FOOD SUBSTITUTI	ONS
Medication Condition that req	uires child to have Food Substit	ution(s): <u>LACTOS</u> F	INTOUCRANT
= 11 1 0 11 1			101 171
Food to be Omitted:			od Substitution:
		509 11111	
I certify that the above named	child requires the food substitu	tions(s) as described fo	r medical reasons:
Print Name and Title: ADX	WENNE BERRY - M	wither -	
Recognized Medical Authority	Signature:	anda Assistanta (DA). Daniista	Date:
(A Recognized Medical Authority	" is a Licensed Physician (MD), Physician	an s Assistants (PA), Register	red Dietitians (RD), Nurse Practioners (NP),

Child/Family Advocates are responsible for ensuring substitute staff are informed of procedures outlined within this allergy and food substitution protocol.

Maintain completed original in Center File with copies to Emergency Contact Binder and HSD.

DEC 0 8 2014

CAVICA	 SEVERE ALLERGY AND F (To Be Completed by Child's 	OOD SUBSTITUTION	ON PROTOCOL			
Child's Name: 1M016	O - BERRY	s Palent and Physician)	Date of Birth: 7/14/09			
Provider Name:			Telephone:			
OBTAIN PRESE	an for allergy concerns? If so, ple	of MUK				
Has allergy been "diagnosed"	by child's physician? Yes No	If "Yes", what was	the diagnosis and when was it made?			
	zed for a severe allergic reaction?					
EMERGENCY ACTION is necessary when child has symptoms such as: NOW						
MEDICATIONS should be ad	ministered by Head Start staff wh	en: NONE				
Give MEDICATIONS as folio	ows:	70.0				
Name of Medication	Method of Administration	Dosage	Frequency of Use-When to use			
Check for possible side effect	s such as: MA					
			C CTAFE MUCT CALL 011			
	SIGNS OR SYMPTOMS O		AS WELL AS CONTACT THE			
CHILD'S PARENTS.	-Macket Wilbload Hear	ONOL OTOTEM	AG WELL AG GONTAGT THE			
For purposes of this protocol "severe allergy" refers to any allergic reaction where exposure to the allergen or causative agent is know to be or may become "life threatening". Any reaction where symptoms of "Anaphylaxis" are present, such as; tightness of chest or throat, breathing difficulty, wheezing, swollen or blue lips, swollen tongue or throat, hives or rash, shall be considered "life threatening".						
Special Instructions: Num						
opecial moti detions.						
of 10 . 20 14, through the	MERGENCY PROTOCOL to be fall cases emergency protocol for a	nere exists a valid he	ealth reason which makes enacting			
Physician Signature:			Date:			
Parent Signature: Adv	the state of the s		Date: 10/27/14			
(My signature signifies consent for U frames listed above, not to exceed or	MCHS staff to enact the emergency procene year.)	edures identified by my ch	Date: 10/27/14 ild's physician and in accordance with the time			
Medication Condition that req	MEDICAL STATEMENT FOR uires child to have Food Substitut	R FOOD SUBSTITUT	TIONS E INTOUTYEARNA			
20						
FLUID COUS M	nuk	SOYMI	ood Substitution:			
I certify that the above named	I child requires the food substitution	ons(s) as described	for medical reasons:			
Print Name and Title:	NOWE BEERE-1	not How				
Recognized Medical Authority	Signature:		Date: tered Dietitians (RD), Nurse Practioners (NP),			
(A "Recognized Medical Authority Registered Nurses (RN),	" is a Licensed Physician (MD), Physiciar Naturopathic Physician (NP), Doctor of O	n's Assistants (PA), Regist steopathy (DO), and Natu	tered Dietitians (RD), Nurse Practioners (NP), ropathic Doctor of Osteopathy (NDO).			

Child/Family Advocates are responsible for ensuring substitute staff are informed of procedures outlined within this allergy and food substitution protocol.

Maintain completed original in Center File with copies to Emergency Contact Binder and HSD.