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.

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)

[redacted] - **SEVERE ALLERGY AND FOOD SUBSTITUTION PROTOCOL**

(To Be Completed by Child's Parent and Physician)

Child's Name: SEQUOYA BERRY Date of Birth: 4/12/11

Provider Name: _____ Telephone: _____

Has child ever seen a physician for allergy concerns? If so, please explain: YES, WAS ABLE TO OBTAIN PRESCRIPTION FOR SOY MILK

Has allergy been "diagnosed" by child's physician? Yes ☐ No ☒ If "Yes", what was the diagnosis and when was it made? COULD NOT DIAGNOSE W/ OUT MORE TESTING

Has child ever been hospitalized for a severe allergic reaction? Yes ☐ No ☒ If "Yes" please explain: _____

EMERGENCY ACTION is necessary when child has symptoms such as: NONE

MEDICATIONS should be administered by Head Start staff when: NONE

Give MEDICATIONS as follows:

Name of Medication	Method of Administration	Dosage	Frequency of Use-When to use

Check for possible side effects such as: N/A

IF CHILD SHOWS ANY SIGNS OR SYMPTOMS OF ANAPHYLAXIS STAFF MUST CALL 911 AND INITIATE THE EMERGENCY MEDICAL RESPONSE SYSTEM AS WELL AS CONTACT THE CHILD'S PARENTS.

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: NONE

I request and authorize this **EMERGENCY PROTOCOL** to be followed for the period commencing with the 27 day of 10, 2014, through the 27 day of 10, 2015, as there exists a valid health reason which makes enacting such protocol necessary. In all cases emergency protocol for allergy shall be reviewed by Head Start staff annually.

Physician Signature: _____ Date: _____

Parent Signature: [signature] Date: 10/27/14

(My signature signifies consent for UMCHS staff to enact the emergency procedures identified by my child's physician and in accordance with the time frames listed above, not to exceed one year.)

MEDICAL STATEMENT FOR FOOD SUBSTITUTIONS

Medication Condition that requires child to have Food Substitution(s): LACTOSE INTOLERANT

Food to be Omitted: FLUID COWS MILK

Recommended Food Substitution: SOY MILK

I certify that the above named child requires the food substitutions(s) as described for medical reasons:

Print Name and Title: _____

Recognized Medical Authority Signature: _____ Date: _____

(A "Recognized Medical Authority" is a Licensed Physician (MD), Physician's Assistants (PA), Registered Dietitians (RD), Nurse Practioners (NP), Registered Nurses (RN), Naturopathic Physician (NP), Doctor of Osteopathy (DO), and Naturopathic 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.

RECEIVED
DEC 08 2014

[redacted] - **SEVERE ALLERGY AND FOOD SUBSTITUTION PROTOCOL**

(To Be Completed by Child's Parent and Physician)

Child's Name: HUYANA BERRY Date of Birth: 07/04/07

Provider Name: _____ Telephone: 541-

Has child ever seen a physician for allergy concerns? If so, please explain: YES GET A PRESCRIPTION FOR LACTOSE FREE MILK / SOY MILK

Has allergy been "diagnosed" by child's physician? Yes ☐ No ☒ If "Yes", what was the diagnosis and when was it made? NEEDED FURTHER TESTING FOR DIAGNOSIS

Has child ever been hospitalized for a severe allergic reaction? Yes ☐ No ☒ If "Yes" please explain: _____

EMERGENCY ACTION is necessary when child has symptoms such as: STOMACHE ACHE, HURTFUL GAS, SLIGHTLY BLOATING & DIARRHEA - GIVE WATER, ~~PE~~ RUBBED STOMACHE TO RELIEVE BLOATING / GAS

MEDICATIONS should be administered by Head Start staff when: NONE

Give MEDICATIONS as follows:

Name of Medication	Method of Administration	Dosage	Frequency of Use-When to use

Check for possible side effects such as: STOMACHE PAINS, BLOATING & DIARRHEA

IF CHILD SHOWS ANY SIGNS OR SYMPTOMS OF ANAPHYLAXIS STAFF MUST CALL 911 AND INITIATE THE EMERGENCY MEDICAL RESPONSE SYSTEM AS WELL AS CONTACT THE CHILD'S PARENTS.

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: HAS NEVER HAPPENED

I request and authorize this **EMERGENCY PROTOCOL** to be followed for the period commencing with the 27 day of 10, 2014, through the 27 day of 10, 2015, as there exists a valid health reason which makes enacting such protocol necessary. In all cases emergency protocol for allergy shall be reviewed by Head Start staff annually.

Physician Signature: _____ Date: _____

Parent Signature: Adrienne Berry Date: 10/27/14

(My signature signifies consent for UMCHS staff to enact the emergency procedures identified by my child's physician and in accordance with the time frames listed above, not to exceed one year.)

MEDICAL STATEMENT FOR FOOD SUBSTITUTIONS

Medication Condition that requires child to have Food Substitution(s): LACTOSE INTOLERANT

Food to be Omitted: fluid milk

Recommended Food Substitution: soy milk

I certify that the above named child requires the food substitutions(s) as described for medical reasons:

Print Name and Title: ADRIENNE BERRY - MOTHER -

Recognized Medical Authority Signature: _____ Date: _____

(A "Recognized Medical Authority" is a Licensed Physician (MD), Physician's Assistants (PA), Registered Dietitians (RD), Nurse Practioners (NP), Registered Nurses (RN), Naturopathic Physician (NP), Doctor of Osteopathy (DO), and Naturopathic Doctor of Osteopathy (NDO).

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[redacted] - SEVERE ALLERGY AND FOOD SUBSTITUTION PROTOCOL

(To Be Completed by Child's Parent and Physician)

Child's Name: INDIGO - BERRY Date of Birth: 7/14/09

Provider Name: Telephone:

Has child ever seen a physician for allergy concerns? If so, please explain: YES, WAS ABLE TO OBTAIN PRESCRIPTION FOR SOY MILK

Has allergy been "diagnosed" by child's physician? Yes ☐ No ☑ If "Yes", what was the diagnosis and when was it made? COULD NOT DIAGNOSE W/ OUT MORE TESTING

Has child ever been hospitalized for a severe allergic reaction? Yes ☐ No ☒ If "Yes" please explain:

EMERGENCY ACTION is necessary when child has symptoms such as: NONE

MEDICATIONS should be administered by Head Start staff when: NONE

Give MEDICATIONS as follows:

Name of Medication	Method of Administration	Dosage	Frequency of Use-When to use

Check for possible side effects such as: N/A

IF CHILD SHOWS ANY SIGNS OR SYMPTOMS OF ANAPHYLAXIS STAFF MUST CALL 911 AND INITIATE THE EMERGENCY MEDICAL RESPONSE SYSTEM AS WELL AS CONTACT THE CHILD'S PARENTS.

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: NONE

I request and authorize this **EMERGENCY PROTOCOL** to be followed for the period commencing with the 27 day of 10, 2014, through the 27 day of 10, 2015, as there exists a valid health reason which makes enacting such protocol necessary. In all cases emergency protocol for allergy shall be reviewed by Head Start staff annually.

Physician Signature: Date:

Parent Signature: [redacted] Date: 10/27/14

(My signature signifies consent for UMCHS staff to enact the emergency procedures identified by my child's physician and in accordance with the time frames listed above, not to exceed one year.)

MEDICAL STATEMENT FOR FOOD SUBSTITUTIONS

Medication Condition that requires child to have Food Substitution(s): LACTOSE INTOLERANT

Food to be Omitted:	Recommended Food Substitution:
FLUID COWS MILK	SOY MILK

I certify that the above named child requires the food substitutions(s) as described for medical reasons:

Print Name and Title: ADRIENNE BERRY - MOTHER

Recognized Medical Authority Signature: Date:

(A "Recognized Medical Authority" is a Licensed Physician (MD), Physician's Assistants (PA), Registered Dietitians (RD), Nurse Practioners (NP), Registered Nurses (RN), Naturopathic Physician (NP), Doctor of Osteopathy (DO), and Naturopathic Doctor of Osteopathy (NDO).

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