

# MILK SUBSTITUTION FORM

Does the student have a milk allergy (disability) requiring a milk substitution other than a lactose-free milk substitute nutritionally equivalent to cow's milk? (Check one)

Yes  No

**If Yes: A Qualified Medical Authority\*, also must complete Part II of this form.**

## **General Information:**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Please explain why your child needs a milk replacement that is lactose-free.

Additional Comments: \_\_\_\_\_

## **Part II: For Qualified Medical Authority\* to Complete (Only complete this if child has a disability, medical need, and/or impairment)**

Student's disability/medical need/impairment (explain): \_\_\_\_\_

How does the impairment listed above restrict his/her diet? (explain): \_\_\_\_\_

Major life activity affected by the student's disability: \_\_\_\_\_

Omitted Beverage(s)	Allowed Substitution(s)

Additional Comments: \_\_\_\_\_

I certify that the above named student needs a milk substitution due to a disability/ medical need/ impairment.

\_\_\_\_\_  
Medical Authority Signature

\_\_\_\_\_  
Medical Authority Printed Name

\_\_\_\_\_  
Office Phone Number

\_\_\_\_\_  
Date

\*A qualified medical authority is a medical professional who has prescriptive privileges in the state of Indiana.

*Signing the following section is optional, but may prevent delays by allowing school personnel to speak with the medical authority.*

### **Health Insurance Portability and Accountability Act Waiver (HIPPA)**

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and Family Educational Rights and Privacy Act (FERPA), I hereby authorize \_\_\_\_\_ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to

\_\_\_\_\_ (school/program), and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, with the SCHOOL PROGRAM as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on \_\_\_\_\_ (date). This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent/guardian/or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE RETURN YOUR COMPLETED FORM TO \_\_\_\_\_