PARENTAL REQUEST FOR A FLUID MILK SUBSTITUTION FOR CHILDREN IN CHILD CARE

1. NAME OF AGENCY 4Cs OF ALAMEDA COUNTY	2. NAME OF SITE(PROVIDER'S NAME)	3. SITE TELEPHONE NUMBER
4. CHILD'S NAME		5. AGE OR DATE OF BIRTH
6. NAME OF PARENT/LEGAL GUARDIAN		7. TELEPHONE NUMBER

8. **The above listed child does not have a disability, but the parent or legal guardian is requesting a fluid milk substitute due to a medical or other special dietary need. This form is not intended to accommodate children who drink fluid milk substitutions such as soy milk due to taste preferences. The child care agency has the discretion to select a specific brand of milk substitute since acceptable products must meet specified nutrient requirements. Juice cannot be offered as a fluid milk substitute for children with medical or special dietary needs that do not rise to the level of a disability.**

This written statement will remain in effect until the parent or legal guardian revokes such statement or until the child care agency discontinues the fluid milk substitution option. Child care agencies participating
In federal nutrition programs are encouraged, but not required, to accommodate reasonable requests. The child's parent or legal guardian must sign this form.

9. MEDICAL OR OTHER SPECIAL DIETARY NEED REQUIRING A FLUID MILK SUBSTITUTION:	13. *The following soy milk brands are acceptable. Please check the milk the above child will be served:* ☐ Silk Original Soymilk ☐ *8th CONTINENT* (Original/Vanilla) ☐ *Pacific Natural Foods* (Ultra) ☐ Kirkland Organic soy milk (Plain)

10. SIGNATURE OF PARENT/LEGAL GUARDIAN	11. PRINTED NAME OF PARENT/GUARDIAN	12. DATE

The information on this form should be updated, as needed, to reflect the current medical and/or nutritional needs of the child.