Milk Substitute Request
Participants without Disabilities

WebCAF #: _____

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

Name of Participant: _____

Part II Substitution

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

List food to be omitted from diet:

Fluid Milk

List food to be substituted:

Nutritionally Equivalent Milk Substitute

Medical or other dietary need for substitution:

_____

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

_____

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

Date: _____

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