PARENT REQUEST FOR NON-DAIRY MILK SUBSTITUTE

Provider Name: ___________________________________________ Date: ____________

Please Print

I am requesting that my child, ________________________________, receive (check one)

☐ Pacific Brand Ultra Soymilk, plain or vanilla
☐ 8th Continent Original Soymilk
☐ Silk Original Soymilk
☐ Walmart Great Value Original Soymilk
☐ Other: ___________________________ (this option must meet milk substitute nutrition standards)

My child has no disability but I would like him/her to receive the non-dairy milk substitute
circled above for the reason I have indicated below: (check reason)

☐ milk intolerance/allergy (Note: These conditions are not considered a disability unless a physician indicates it as such)
☐ vegan diet
☐ religious reason
☐ cultural reason
  (explain) ____________________________________________________________
☐ ethical reason
  (explain) ____________________________________________________________

I understand my provider is not required to supply the non-dairy milk substitute since the substitution is
not being requested due to a disability.

______________________________
Parent/legal guardian signature

This form needs to be renewed annually. Note to provider: please keep a copy on file and send a
copy to 4-C. Should this information change, please submit a written note from the parent indicating
the change and effective date.

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