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 I understand that permission to release this information may be rescinded at any time except when the information has already been released.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 .

This institution is an equal opportunity provider.

Modified 7/20/2018

Minnesota Department of Education

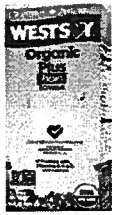
Fluid Milk Substitutions in the Child Nutrition Programs

Non-Dairy Beverages Meeting United States Department (USDA) of Agriculture Substitution Criteria per Eight Fluid Ounces

Nutrients	USDA Criteria per Eight Fluid Ounces	*8th Continent* Original Soymilk	*8th Continent* Vanilla Soymilk*	*Pacific* All Natural Ultra Soy Original	*Pacific* All Natural Ultra Soy Vanilla*	*Kikkoman* Pearl Organic Soymilk Smart Original	*Kikkoman* Pearl Organic Soymilk Smart Creamy Vanilla*	*Kikkoman* Pearl Organic Soymilk Smart Chocolate*	*Walmart Great Value* Original Soymilk
									
Calcium (mg)	276	300	300	285	285	373	408	395	300
Protein (g)	8	8	8	10	10	8.9	9	8.4	8
Vitamin A (IU)	500	500	500	500	500	1249	1220	1219	500
Vitamin D (IU)	100	100	100	100	100	255	205	191	120
Magnesium (mg)	24	24	24	52.47	52.44	54	51	64	40
Phosphorus (mg)	222	250	250	254	254	313	294	301	250
Potassium (mg)	349	380	380	381	381	377	407	530	360
Riboflavin (mg)	0.44	0.51	0.51	0.49	0.49	0.96	1.02	1.04	0.51
Vitamin B12 (mcg)	1.1	1.2	1.2	1.47	1.47	2.31	1.86	1.46	3
Packaging		8, 32 or 64 fl. oz. carton	32 fl. oz. carton	32 fl. oz. carton	32 fl. oz. carton	8 fl. oz. single-serve size	8 fl. oz. single-serve size	8 fl. oz. single-serve size	64 fl. oz. carton

The Minnesota Department of Education does not endorse the companies or products listed. This chart is for informational purposes only. Contact the manufacturer at the time of purchase to ensure that product formulations have not changed.

*Flavored fluid milk substitutues noted with an asterisk (*) served to children 1-5 years old cannot be claimed for reimbursement.

Nutrients	USDA Criteria per Eight Fluid Ounces	*Sunrich Naturals* Original Soymilk 	*Sunrich Naturals* Vanilla Soymilk* 	*Sunrich Naturals* All Natural Original Soymilk 	*Sunrich Naturals* All Natural Vanilla Soymilk* 	*Sunrich Naturals* All Natural Unsweetened Vanilla Soymilk* 	*Silk* Original Soymilk 	*Westsoy* Organic Plus Plain 	*Westsoy* Organic Plus Vanilla* 
Calcium (mg)	276	300	300	300	300	300	450	276	276
Protein (g)	8	8	8	8	8	8	8	8	8
Vitamin A (IU)	500	500	500	500	500	500	500	1000	1000
Vitamin D (IU)	100	100	100	100	100	100	120	100	100
Magnesium (mg)	24	40	40	40	40	40	60	60	60
Phosphorus (mg)	222	228	228	228	228	228	250	250	250
Potassium (mg)	349	360	360	360	360	360	380	440	440
Riboflavin (mg)	0.44	0.45	0.45	0.45	0.45	0.45	0.51	.51	.51
Vitamin B12 (mcg)	1.1	1.1	1.1	1.2	1.2	1.2	3	3	3
Packaging		8 fl. oz. carton	8 fl. oz. carton	32 fl. oz. carton	32 fl. oz. carton	32 fl. oz. carton	32 or 64 fl. oz. carton	32 or 64 fl. oz. carton	32 or 64 fl. oz. carton

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Special Dietary Needs Medical Statement

This school/facility participates in a federally funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable meal accommodations must be made when the accommodation requested is due to a disability or impairment. If you are requesting a meal accommodation or substitution, please complete and sign this form. A physician note or statement may be required. If you have any questions, please contact Tonia Batesole at Tonia.Batesole@PTSC.K12.IN.US

Parent/Guardian:

Student's Name	Date of Birth	Grade Level/Classroom	Name of School/Site

Name of Parent/Guardian	Phone Number of Parent/Guardian

Please provide an explanation below of how the student's physical or mental impairment restricts the student's diet.

Allergies and Intolerances	
	What food(s)/type(s) of foods should be omitted? Please be as specific as possible.
	List foods to be substituted.

Signature of Parent/Guardian	Date

Medical Authority:

Texture Modifications	**The child requires foods be:** ☐ Pureed ☐ Diced/Finely Ground ☐ Chopped/cut into bite-size pieces ☐ Other (please specify):	**Liquids should be:** ☐ Pudding Thick ☐ Honey/Nectar Thick ☐ Thinned ☐ Other (please specify):
Adaptive Eating	**Please list any required special adaptive equipment:**	
Additional Information	**Please provide any additional information.**	

Name of Physician/Medical Authority & Title (please PRINT)	Provider Phone Number
Signature of Physician/Medical Authority	**Date**

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:**_____

School/Faculty Use Only:

☐ Form Received on _____. ☐ Accommodation will begin on _____.

☐ Accommodations within meal pattern. ☐ Accommodations not within meal pattern.

☐ Form incomplete. Parent contacted on _____.

☐ Form complete. Accommodation will not be made. ☐ Request not reasonable. ☐ 504 coordinator contacted

_____ _____

Date Signature of Food Service Director/Contact

Process for Requesting Accommodations for Special Dietary Needs

Porter Township adheres to specific USDA guidelines in providing special diet accommodations for students. In accordance with the criteria set forth in 7 CFR Part 15b, those students who are unable to eat the school meal due to a disability/medical need/or impairment are accommodated, at no additional charge. Dietary needs due to lifestyle and religious reasons are important to our school but not a requirement by USDA to make accommodations. Our school will try to accommodate lifestyle and religious needs through our current menu choices. Please review the following information if your child requires special diet consideration.
Per Section 504 of the Rehabilitation Act of 1973, parents have a right to an evaluation of your child if the district has reason to believe that your child has a mental or physical impairment that substantially limits a major life activity, which can involve eating/digestion. You have the right to this evaluation before any plan for accommodation.
The steps in the process to request special accommodations are 1) for the parent(s)/caregiver(s) to complete the Special Dietary Needs Medical Statement form and immediately return to the school; 2) the school will review and process the request; 3) the form may be returned to parent/guardian for additional medical signatures. For example, if the substitutions needed for accommodations fall outside of the USDA meal pattern, the Medical Statement form must be signed by an authorized medical authority with prescriptive privileges in the state of Indiana, and 4) accommodations will be adjusted accordingly based on review.

Procedural Safeguards

If the household feels accommodations are not being met, they have the right to contact the 504 Coordinator and:

- File a grievance if they believe a violation has occurred regarding the request for a reasonable modification;
- Receive a prompt and equitable resolution of the grievance;
- Request and participate in an impartial hearing to resolve their grievances;
- Be represented by counsel at the hearing;
- Examine the record; and
- Receive notice of the final decision and a procedure for review, i.e., right to appeal the hearing's decision.

Accommodations Coordinator

- The safety of your child comes first. If you have a child with a disability/medical need or impairment, please submit your request for accommodation by completing this form and submitting to Tonia Batesole.
- For more information about accommodations to school meals and the meal service for students with disabilities at Porter Township, please contact: **Tonia Batesole 260 South 500 West Valparaiso, IN 46385 or Tonia.Batesole@PTSC.K12.IN.US.**

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.
Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.
To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:
(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.