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| Community Colleges of Spokane Logo | | | | Spokane Head Start/ECEAP/EHS  REQUEST FOR FLUID MILK SUBSTITUTION | | | | | | | | | | | |
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| Spokane County Head Start/ECEAP/EHS is committed to providing high quality and healthy food choices for all children. If your child has a special, non-life-threatening diet need, we will consider a parent request for fluid milk substitution. The Child and Adult Care Food Program (CACFP) have set standards for the foods we serve and we are mandated to follow them. Flavored non-dairy beverages cannot be served to children 1–5 years of age. | | | | | | | | | | | | | | | |
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| **Non-dairy milk substitution request** | | | | | | | | | | | | | | | |
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| At this time, only six brands of non-dairy milk substitutes are available in Washington that meet the definition of being nutritionally equivalent to cow’s milk. All are original and plain or unflavored products: | | | | | | | | | | | | | | | |
| 1. 8th Continent Soymilk | | | | | | | | 1. Great Value Soymilk from WalMart (red top only) | | | | | | | |
| 1. Pacific Foods Ultra Soy | | | | | | | | 1. Kirkland Organic Soy (Plain) | | | | | | | |
| 1. Silk Soymilk | | | | | | | | 1. Ripple Dairy-Free Shelf-Stable Milk | | | | | | | |
| By completing the information below, your child will be served a fluid milk substitution. | | | | | | | | | | | | | | | |
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| Name of participating child: | | | | | | |  | | | Date of birth: | | |  | | |
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|  | **Identify why your child requires a non-dairy milk substitute (for example: milk intolerance, vegetarian or religious restriction):** | | | | | | | | | | | | | | |
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|  | I request that my child be served one of the available soy beverages. All other foods on the menu made with milk may be offered including items: like pizza, yogurt, cheese sticks, cottage cheese and macaroni and cheese.1 | | | | | | | | | | | | | | |
|  | or | | | | | | | | | | | | | | |
|  | I will provide an unapproved non-dairy milk substitute for my child - please list:       . I understand that Head Start/ECEAP/EHS cannot claim meals that require milk unless my child has a documented medical disability, diagnosed by a Recognized Medical Authority, either M.D or D.O, Physician’s Assistant with prescriptive authority (PA), Naturopathic Physician or Advanced Registered Nurse Practitioner (ARNP). | | | | | | | | | | | | | | |
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|  | or | | | | | | | | | | | | | | |
| **Other fluid milk substitution requests** | | | | | | | | | | | | | | | |
|  | I request that my child be served one of the below listed milk substitutions. All other foods on the menu made with milk may be offered including items like pizza, yogurt, cheese sticks, cottage cheese, and macaroni and cheese.1 | | | | | | | | | | | | | | |
|  | | 1% Lactose-reduced milk (whole for children 12-24 months) | | | | | | | 1% Lactose-free milk (whole for children 12-24 months) | | | | | | |
|  | I will provide 1% or nonfat organic milk to be served in the place of the milk served by HS/EHS (whole for children 12-24 months) | | | | | | | | | | | | | | |
| *1If your child cannot consume these foods, additional paperwork may need to be completed.* | | | | | | | | | | | | | | | |
| Signature of Parent/Guardian: | | | | | |  | | | | | | | | Date: |  |
| Site/Room: | | |  | | | | | | | | FSC: |  | | | |