



Milk/Food Allergies

Name of Child: _____ DOB: _____

Milk Allergies:

My child has a milk allergy: _____ YES _____ NO

If yes my child needs:

_____ Lactose Free Whole Milk _____ Lactose Free 1% _____ Almond Milk

The milk allergy is _____ parent preference _____ doctor documented

If parent preference please explain: _____

*If Almond milk is prescribed a doctor note is required.

Food Allergies:

Please list ALL food allergies your child has: _____

What kind of allergic reaction does your child have? _____

Parent signature: _____ Date _____

Food Program Administrator signature: _____