Request for Fluid Milk Substitution – Child Care

Child’s Name: _________________________________________________________________

**Milk substitution request:**

If your child cannot drink fluid cow’s milk due to medical or other special dietary needs but **does not** have a diagnosed medical disability, you or the child care center may choose to provide one of the approved non-dairy milk substitutes or creditable milk substitutes below, based on your request.

Identify why your child needs a milk substitute: ______________________________________

_____________________________________________________________________________

____________________________________

At this time, only five brands of non-dairy milk substitutes available in Washington are nutritionally equivalent to and may be served in place of cow’s milk:

- 8th Continent Soymilk (Original and Vanilla*)
- Great Value Original Soymilk
- Kirkland Organic Soymilk (Plain)
- Pacific Ultra Soy (Plain and Vanilla*)
- Silk Original Soymilk

*Effective October 1, 2017, flavored non-dairy beverages cannot be served to children 1 through 5 years of age. If serving flavored milk to children 6 years of age and older, it must be nonfat milk.

Other milks that are creditable and may be served in place of fluid cow’s milk are acidified milk, acidophilus milk, buttermilk (commercially prepared), goats milk, Kefir milk, lactose-free or reduced milk (such as Lactaid), and organic milk. **Note:** Whole milk must be served to children 12 to 24 months and nonfat or 1% milk must be served to children 2 years of age or older.

By completing the information below, your child can be served one of the approved non-dairy milk substitutes or other creditable milks noted above provided by the center (if the center chooses), or provided by you.

_____ I request my child be served the child care center provided approved non-dairy or creditable milk substitute as described above for meals that require milk.

_____ I will provide an approved non-dairy or creditable milk substitute to be served to my child as described above for meals that require milk:

____________________________________

(______) (Name of approved non-dairy or creditable milk substitute)

Signature of Parent/Guardian: __________________________________ Date: ______________

OSPI/Child Nutrition Services August 2016