Request for Fluid Milk Substitution – Adult Care

Adult Participant’s Name: ____________________________________________

Milk substitution request:

If an adult participant 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 adult 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 the adult participant 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, if flavored milk is served to adult participants, 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: nonfat or 1% milk must be served.

By completing the information below, the adult participant 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 the adult participant be served the adult 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 the adult participant as described above for meals that require milk:

__________________________________________________________________________________________

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

Signature of Household Member/Guardian: ___________________________ Date: ______________

OSPI/Child Nutrition Services

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