IRVING
Independent School District

Food & Nutrition Services

To the Parent/Guardian of: _____ Student ID: _____

School Name: _____

COMPLETE THIS FORM ONLY FOR STUDENTS WITH MILK (LACTOSE) INTOLERANCE

Our school health records indicate that your student has milk (lactose) intolerance. Please complete this form and return it to the school clinic of the school your student attends. This form will be placed in your student's health record and this information will be shared with the Food & Nutrition department staff. If your child's medical or health needs change, it is the responsibility of the parent/or guardian to provide an update, in writing, to the Food & Nutrition Services office and the School Nurse.

Breakfast and Lunch for Early Childhood and Pre-K students at Elementary Schools:

Due to a recent policy change by the United States Department of Agriculture (USDA), the Irving ISD Food & Nutrition Services Department will **ONLY OFFER USDA-approved Ultra Soy Vanilla Milk as the non-dairy milk substitute** for those students whose documented medical condition does not allow the consumption of cow's milk.

Students participating in Early Childhood/Pre-K meal programs do NOT have the option of declining menu items.

Breakfast and Lunch for ALL K-12:

For all meal programs at elementary, middle, and high school, students are permitted to decline several items on the menu, including fluid cow's milk; therefore, soy milk will not be offered to students during these meal periods, unless otherwise requested. Parents are encouraged to send beverages from home.

Please mark one of the following choices: K-12 Students Only
(Early Childhood/Pre-K Students with documented need for lactose intolerance will automatically receive USDA approved soymilk substitute.)

☐ **USDA-approved Ultra Soy Vanilla Milk**
I would like my child to have soy milk provided to them for the entire school year.
*** Please make sure your child will consume this product before requesting this option.*

☐ **No Milk Substitute Needed (*Does not apply to Early Childhood or Pre-K Students*)**

Parent's/Physician's Signature: _____ Date: _____

This institution is an equal opportunity provider.

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