Liquid Milk Allergy –Important – Please Return As Soon As Possible.

Dear Parent/Guardian, Student: ________________________Grade: _____ Date________

According to our cafeteria records, you have in the past requested that your child should not receive –liquid Milk. This letter is an informational letter explaining the new mandate from the United States Department of Agriculture- Food and Nutritional Services regarding implementation of a new "Final Fluid Milk Substitution Rule" in the School Nutritional Program (72FR 52903) for this coming school year.

Please indicate if your child has: **(Please select an option)**

____ (Option 1) a reaction (allergy) to the "**sugar**" in the milk, which would be considered milk sensitivity (Lactose Intolerant) or "**Non-disabling allergies**", culture beliefs, religion or ethical belief (Lactaid will be offered with lunch at no extra charge)

___ (Option 2) an allergy to the "**protein**" in the milk, which would be considered a life threatening disability. Complete the physician form attached

Sugar or Protein Allergy?

SUGAR ALLERGY:

If your child has an allergy to the "**sugar**" in the milk and is lactose intolerant, has a non-disabling dietary need, cultural, religious/ethnic reason to avoid milk, schools **are no longer permitted** to substitute juice or water for milk. Our cafeteria will offer your child "Lactaid" in place of the milk at no additional charge. Your student may purchase a 100% juice or water ($.50-85 cents) adding this addition cost on to the price of a reimbursable meal. You will need to provide this packet to the cafeteria stating that you do **permit** your student to purchase a juice or water. The USDA states that sensitivity to the sugar in milk is not considered life threatening or disabling.

☐ Check here if you give permission for your student to purchase 100%Juice or Water at extra charge of ($.50-.85 cents)
Parent Signature: ___________________________________ Return this packet to your school cafeteria

PROTEIN ALLERGY:

If your child is allergic to the "**protein"** in the milk which is considered a life-threatening disability and could result in anaphylactic shock, you will need to return the attached paperwork signed by a physician **stating that the child has a disability** and this signed form will begin the process of a food safety plan with our **School Nurse** as soon as possible. Your Physician will need to complete the paperwork and prescribe the beverage to omit or substitute. Note: This substitution is **only** permitted if your child has a **protein allergy** which is a life threatening disability, is accompanied by a physician note stating the child is disabled and accompanied with a 504 plan.

If you have selected "Option 2", please note that your child's "protein milk disability" would likely exclude products such as cheese, dairy, pizza, cheeseburger, Doritos, sherbet and other items containing milk. (Avoidance will include: Butter, butter oil, buttermilk, Casein, Cheese, Cream, Cottage Cheese, Custard, Ghee, Half & Half, Hydrolystates, milk protein, whey and whey protein, Latalbumin, Lactalbumin phosphate, Latoglobulin, Lactose, Lactulose, Milk – all forms, Nougat, Pudding, Rennet casein, Sour cream, Whey, Yogurt, caramel, Bavarian cream, coconut cream, butter, chocolate, high protein flour, margarine, Simplesse- there may be others please check with your family Physician) This should also be included on the Physician Forms.

Your immediate attention is needed so that we may implement this new mandate. Please feel free to phone me if you have any questions at (724-693-3019)

Respectfully,

Ms. Tricia Wood, Director of Nutritional Services

Medical Plan of Care for School Food Service

PHYSICIAN FORM

(Student with Disabilities and Non-Disabling Special Dietary Needs)

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs.

- USDA regulations 7CFR Part 15B requires substitutions or modifications in school program meals for children whose disability restricts their diet and is supported by a statement signed by a **licensed physician.** Food allergies which may result in a severe, life-threatening (Anaphylactic) reaction may meet the definition of **"disability."**
- The school **may** choose to accommodate a student with a **non-disabling** special dietary need that is supported by a statement signed by a recognized medical authority (physician, physician assistant or nurse practitioner)
- The school food authority **may** choose to make a milk substitution available for students with a non-disability specialist dietary need, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations. If available, this will be indicated in Part 2. A parent/guardian or recognized medical authority (physicians, physician assistant, or nurse practitioner) may complete this section. If this is the only substitution being requested, complete Part 1 and 2 only.

Part 1: To be completed by Parent /Guardian (all requests for special dietary needs)

Child's Full Name ____ Date of Birth ___________
Circle one: Male Female

Name of School/Center/Program ________________________________ Grade Level/ __________

Parent's /Guardian's Name/Address, City, State, Zip Code Email: __________________________
Print

Home Phone ( ) ______________ Cell Phone ( ) ________________ Work Phone ( ) __________

Part 2: Request for milk substitution for non-disabling special dietary needs only (Lactose Intolerant - sensitivity to sugars in the milk)

South Fayette Twp School District does provide Lactaid as a milk substitute (no cost) to students with non-disabling or other special dietary needs when this section is signed by Medical Authority or Parent/Guardian and approved by the school district. (Juice and water **cannot** be **substituted** for fluid milk as part of the reimbursable meal even when requested by a physician; however, Juice/water can be purchased at additional cost to the reimbursable meal).

Does the child have a non-disabling medical or special dietary need that restricts intake of fluid milk? Yes ☐ No ☐

Do parents give permission for the student to purchase at ***additional cost***, water or 100% Juice? Yes ☐ No ☐

Medical Authority or Parent/Guardian Signature ____________________________________

Part 3: To be completed by **Physician/Medical Authority**
Disability/Special Dietary Needs

Does the child have a disability yes ☐ No ☐
If Yes,
Please describe the major life activities affected by the disability. ____

____

Does the child's disability affect their nutritional or feeding needs? Yes ☐ No ☐

Is the student have Diabetes Yes ☐ No ☐

Is there a need to modify the texture of the food?________________

List any special equipment or utensils that are needed: _________________________________

If the child **does not** have a disability*, does the child have special nutritional or feeding needs? Yes ☐ No ☐
(*these accommodations are optional for school districts)

Part 4: To be completed by **Physician/Medical Authority** (Must be **signed and stamped** with the office name/address of a licensed physician/recognized medical authority.
Diet Order: List any dietary restrictions, such as food allergies, intolerances or restrictions:

Medical Authority or License Physician Signature: ________________________Date__________________
Received by South Fayette Twp School District Nurse/Director _____________________________ Date __________________