

JACKSON COUNTY PUBLIC SCHOOLS
Food and Nutrition Services

Request for Milk Substitution and Lactose-Free Diet

Student Name: _____ Date of Birth: _____

School Name: _____

Restriction: Milk – Lactose Intolerance

Reason:

Student will drink:

- Lactose-Free Milk
- OR
- Soy Milk

Check additional items to be restricted:

- Milk ingredient in cooked foods
- Cheese
- Yogurt
- Other: _____

Parent/Guardian Signature: _____

Date: _____

Return completed and signed form to the school nurse and/or cafeteria manager.