Parental Request For A Non – Dairy Milk Substitution

Provider Name:_____

Provider Number: _____

Telephone: (_____) _____

Dear Parent:

Your child, _____, is a participant in the USDA Child and Adult Care Food Program (CACFP). This program provides Federal and State funds to supply nutritious meals for children in a licensed, or Trustline approved child care home. The USDA Meal Pattern Requirements now include the requirement that 1% or non-fat cow's milk be served to children 2 years or older. Children between the age of 1 to 2 years should continue to have whole milk.

Parents that prefer their child receive a non-dairy milk substitute due to a medical, or other special dietary needs (other than a disability), are required to have a signed written request on file with the caregiver and the sponsor of the program. All non-dairy substitutions must be nutritionally equivalent to milk and meet the nutritional standards for fortification of calcium, protein, vitamin A, vitamin D, and other nutrient levels found in cow's milk. These nutritional requirements are (per cup):

Calcium …… 276mg Protein …….. 8g Vitamin A …… 500IU Vitamin D ……. 100IU
Magnesium …… 24mg Phosphorus … 222mg Potassium ….... 349mg Riboflavin ……. 0.44mg
Vitamin B-12 .. 1.1mcg

Please complete the form below . You must specify the type and brand of milk substitute the child is to be served in place of cow's milk. This information will allow your child care provider to provide meals to your child that conform to USDA Meal Pattern requirements.

This statement allows your child care provider to serve the requested substitution and still be reimbursed for the meal. Your assistance in providing this information is greatly appreciated. If you have any questions about this form, or CACFP, please contact our Program Manager at (209) 578-4792 or (800) 755-4792.

Parents that desire their children, 2 years and older, to have whole or 2% milk instead of 1% or non-fat milk must get a medical statement signed by a doctor. Contact FRAMAX at (209) 578-4792 for the form.

This Section to be Completed by the Parent/Guardian and Provider

Please Type or Print in Blue or Black Ink Only

TO: FRAMAX

Child's Name: _____

Parent/Guardian's Name: (Print) _____

Child is not to have the following: 1% or non-fat cow's milk

Due to the following medical or other special dietary needs: _____

In place of cow's milk, the child should have the following milk substitute:

Type of milk substitute: _____

Brand of milk substitute: _____

Date: _____ Parent Signature: **_____

**My signature indicates that the non dairy milk substitute meets the nutritional requirements specified above.

The provider understands that all non dairy beverages must meet the fortification and nutritional requirements specified above and will maintain documentation in the FCCH for review during any announced or unannounced home review.

Date: _____ *Provider Signature:* _____