School District of Monroe

PRESCRIPTION CONSENT for Milk Alternative

Please complete both sections.

STUDENT NAME: _____ BIRTHDATE: _____

GRADE: _____ HOME ROOM: _____ SCHOOL: _____

***** A new note or this form will need to be completed on an **annual** basis if your child receives a milk alternative at school

FOR COMPLETION BY PHYSICIAN or HEALTH CARE PROVIDER

Breakfast Alternative is: (Please circle one)

Soy Milk **Lactase (Lactaid free)** **Almond Milk**

Snack Break Alternative: (please circle) **Juice**

Lunch Alternative is: (Please circle one)

Soy Milk **Lactase (Lactaid free)** **Almond Milk**

PHYSICIAN/ PROVIDER SIGNATURE: _____ DATE: _____

Clinic Address: _____ Phone: _____

FOR COMPLETION BY PARENT

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Home Phone: _____ Work Phone: _____