weca Wisconsin Early Childhood Association

Special Diet/Non-Dairy Substitute Form

WECA provider's first/last name: _____ 6-digit WECA ID#:_____

Child's first/last name: _____ ID#: _____ Child's date of birth: _____

THIS CHILD IS ONE YEAR OR OLDER & MAY HAVE DAIRY MILK OMITTED DUE TO PARENT CHOICE/LIFESTYLE.
Requires parent signature and check mark only. Parent: Put a check mark in the box of your approved milk substitute(s) below, print your name, date, and sign. The ONLY milk substitutes nutritionally equivalent to milk that are currently approved by USDA are:

Ages 1-5 years:

- ☐ Walmart Great Value Soymilk: Original
- ☐ 8th Continent Soymilk: Original
- ☐ Sunrich Naturals: Original Soymilk
- ☐ Kirkland Signature Organic Soymilk: Plain
- ☐ Pacific All Natural Ultra Soy: Original
- ☐ Silk Soymilk: Original

Ages 6+ years:

- ☐ 8th Continent Soymilk: Original/Vanilla
- ☐ Kikkoman Pearl Organic Soymilk Smart: Chocolate/Creamy Vanilla
- ☐ Kirkland Signature Organic Soymilk: Plain
- ☐ Sunrich Naturals: Original Soymilk/Vanilla Soymilk
- ☐ Walmart Great Value Soymilk: Original
- ☐ Pacific All Natural Ultra Soy: Original/Vanilla
- ☐ Silk Soymilk: Original

Print name: _____

Parent signature: _____ Date: _____

THIS CHILD IS ONE YEAR OR OLDER & REQUIRES A DIETARY CHANGE. Must be signed by physician OR other recognized medical authority:

Specify change: _____

Reason for change: _____

Substitute(s): _____

Print medical authority name: _____ Signature: _____

Clinic name: _____ Phone#: _____ Date: _____

THIS CHILD IS ONE YEAR OR OLDER & MAY HAVE FOOD(S) OMITTED DUE TO SEVERE ALLERGY/DISABILITY. Must be signed by physician:

Food(s) to omit: _____

Substitute(s): _____

Print physician name: _____ Signature: _____

Clinic name: _____ Phone#: _____ Date: _____

THIS CHILD IS AN INFANT (LESS THAN ONE YEAR). Must be signed by physician OR other recognized medical authority.

☐ **Infant may have iron-fortified infant formula omitted.** Note: This form is NOT required for iron-fortified soy formula.

Reason for omission: _____

Substitute(s): _____

☐ **Infant: Other change**_____

Reason for omission: _____

Substitute(s): _____

Print medical authority name: _____ Signature: _____

Clinic name: _____ Phone#: _____ Date: _____