SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Early Learning and Care Department

Lactose Intolerance History

(Parent/Guardian to Complete and Return to Nurse)

Student Name: ________________________________ Date of Birth: _______________

Parent/Guardian: ______________________________ School: _____________________

IMPORTANT NOTE:
If your child has history of **FOOD ALLERGY to MILK OR DAIRY** with symptoms such as rash, hives, swelling or difficulty breathing) DO NOT complete this form and ask to speak to your nurse.

If your child has **LACTOSE INTOLERANCE** please complete this form.

Past symptoms of lactose intolerance:

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Please check the boxes below that apply to your child:

My child can **NOT** have:

☐ Cow's milk (liquid)

However, my child **CAN** have:

☐ Lactose Free Milk

☐ Cow's milk as an ingredient in food

☐ Yogurt ☐ Cheese ☐ Pudding

______________________ _____/______________ ____________________ _________
Parent Signature Date/Phone Nurse Signature Date

*******************************For Office Staff Use Only*************************

Original: ☐ Class file
cc: ☐ Sub-teacher binder ☐ Emergency Contact Card ☐ Health Cum ☐ Nurse ☐ Parent
☐ Scanned to Nutrition Services: Initials/Date: ____________