SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Child Development Department

Lactose Intolerance History

(Parent/Guardian to Complete and Return to Nurse)

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ School: _____ ___

If your child has history of **MILK OR DAIRY ALLERGY** (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:

_____

_____.

Please check the boxes below that apply to your child:

My child can **NOT** have:

_____ Cow's milk (plain)

_____ Cow's milk (in foods)

_____ Yogurt

_____ Pudding

_____ Cheese

My child **CAN** have:

_____ Lactaid (lactose free) milk

_____ Cow's milk in foods

_____ Yogurt

_____ Pudding

_____ Cheese

Please note: Nutrition Services cannot provide any milk substitute except for Lactaid milk. Please talk to your nurse if you are wanting to provide a milk substitute for your child.

_____	_____	_____	_____
Parent Signature	Date/Phone	Nurse Signature	Date