

**Moorhead Area Public Schools
Request for Lactose Free Milk**

Name: _____ DOB: _____

Teacher: _____ Grade: _____ School: _____

I am requesting lactose free milk be provided to my student at school. I understand that if there are other dietary requirements or limitations I need to complete a Special Dietary Statement Form that can be obtained from the school office.

Parent Signature: _____ Date: _____

Primary Phone: _____ Secondary Phone: _____

Please return this form to the school health office.

Copies provided to:

_____ Health Office (Upload into PowerSchool) _____ Kitchen _____ Main Office