CDC
CHILD DEVELOPMENT CENTER
PO Box 1117 1602 W. Ferguson Rd
Mt. Pleasant TX 75455
(903)575-2092 fax (903)575-2077

Year: _____

Dairy Allergy/Intolerance Evaluation
Evaluación de intolerancia/Alergias lácteas

Child's name/*Nombre del Niño*	Birthday/*Fecha de Nacimiento*	Room/# de *Salón*

Select One / Seleccione Uno: ☐ Early Head Start ☐ Head Start ☐ Pre-K ☐ PPCD

Your child's medical Provider must fill out the following information

El proveedor Médico de su niño debe llenar la siguiente información

1. Does the child have any medical conditions? If yes, please list them below.

☐ **YES** ☐ **NO**

2. List any dietary restrictions or special diet

- ☐ ***Dairy Allergy***
  - this includes all food/drinks prepared with dairy products. i.e. butter, cheese, milk, cream, yogurt, pudding, ice cream, pizza, etc.
- ☐ ***Lactose Intolerant***
  - this includes all food/drinks containing lactose
- ☐ ***Milk to drink only***
  - child may have foods containing dairy products but needs a substitution to drink
- ☐ ***Other***

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3. Please provide a substitution option for dairy milk:

- ☐ **Lactose-Free Cow's Milk**
- ☐ **Soy Milk (choose a flavor below):**
  - ☐ Vanilla
  - ☐ Non-Flavored
- ☐ **Other**:

4. What type of reaction should we expect if child consumes this product & emergency treatment plan:

Parent or Guardian Signature/Firma del Padre o Tutor: _____ Date/Fecha:_____

Doctor Signature/Firma del Doctor: _____ Date/Fecha:_____

Teacher Signature/Firma del Maestro(a): _____ Date/Fecha:_____

Cafeteria Manager Signature/Firma del Gerente de la Cafetería: _____ Date/Fecha:_____

Health Staff Signature/Firma de Personal de la Salud: _____ Date/Fecha:_____