Lactose Intolerance and Milk Allergy

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Soy packages for children

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Anyone you know who cannot drink milk?

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Lactose

intolerance **=**

(milk sugar)

Less

Lactase

(enzyme)

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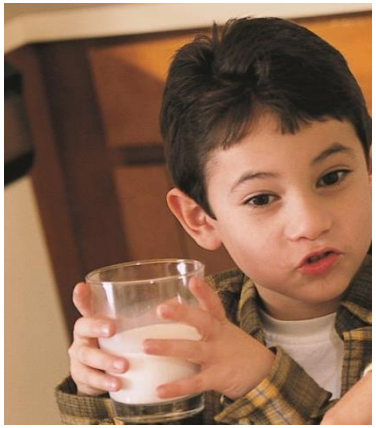
Lactase (enzyme) + Lactose =



Lactase (enzyme) + Lactose =

Cramps
Diarrhea
Gas
Bloating

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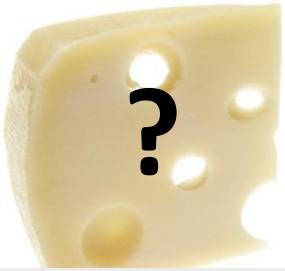
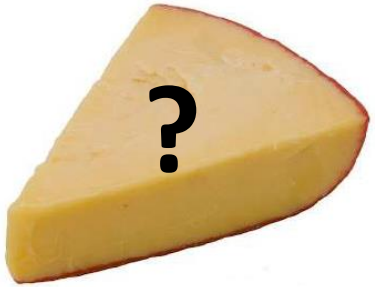
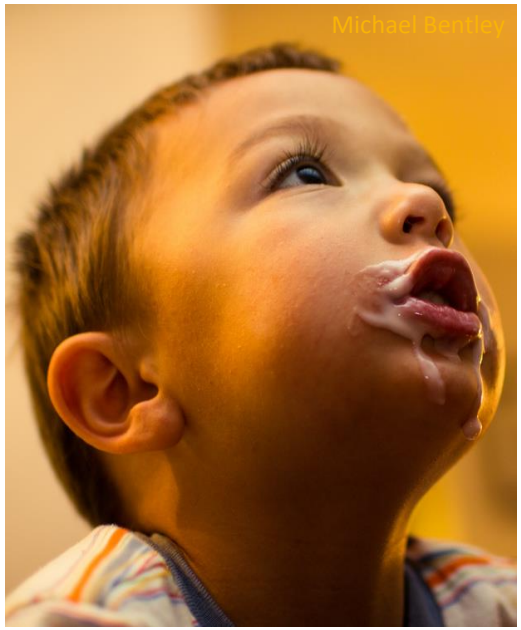
Some dairy may be OK







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Lactose Free

1% Milk

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Who might have a hard time with lactose?

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2/3 of everyone

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Milk Allergy = Immune response (milk protein sensitivity)

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Milk Protein Sensitivity (allergy)

+

Milk Protein

=

Vomiting
Diarrhea
Anaphylaxis

Rash
Hives
Wheezing

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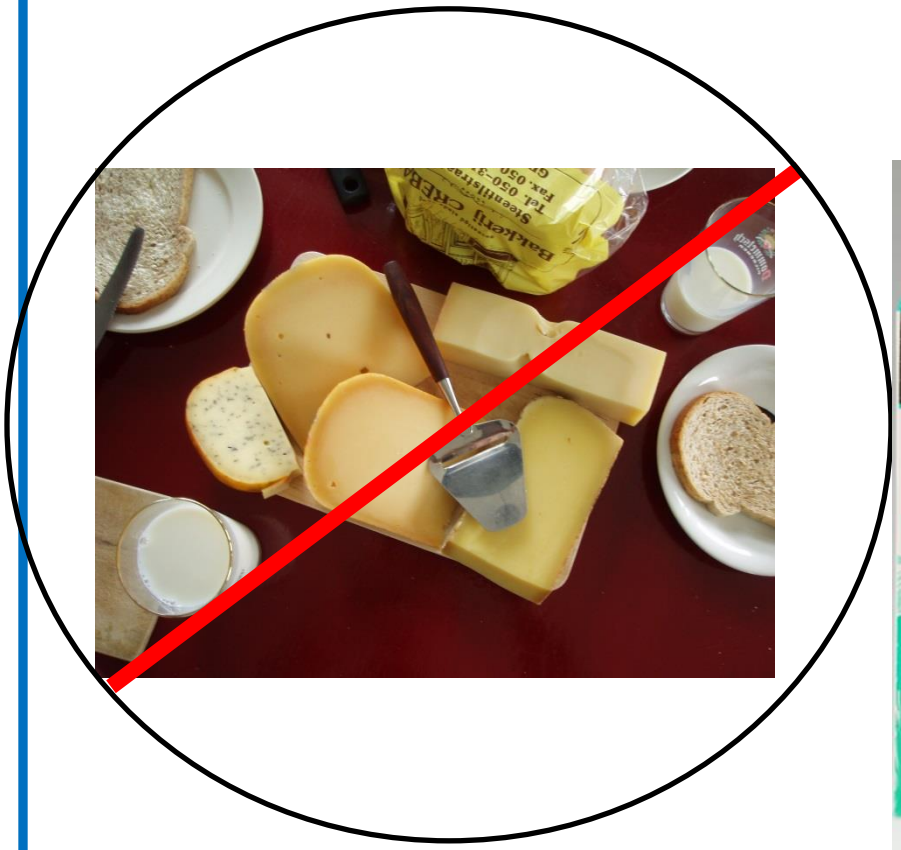

?

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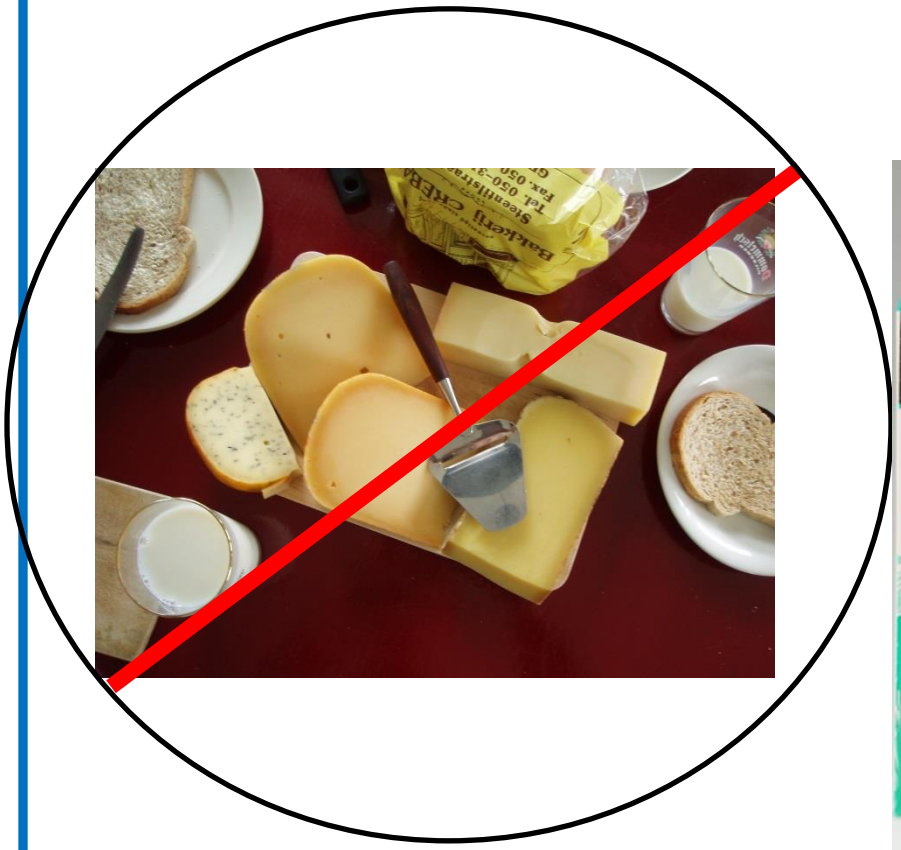

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Less common in older children

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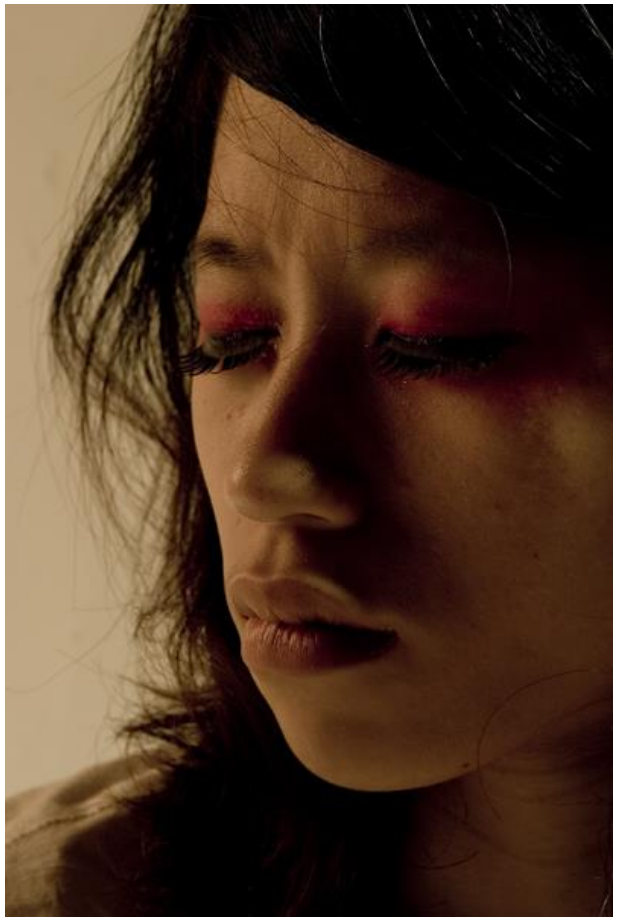
Compare



Lactose Intolerance

Milk Protein Allergy

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Milk Alternatives

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Why might WIC families want to decrease or eliminate dairy?

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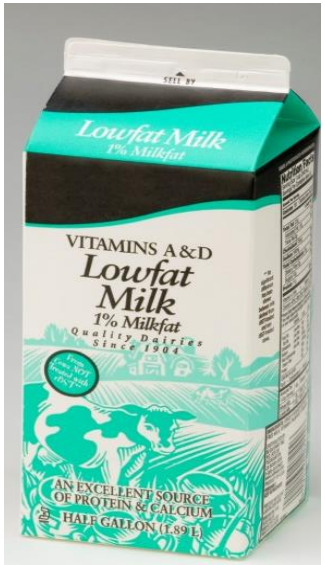
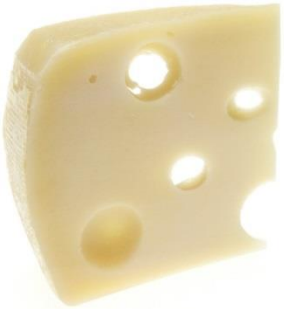
CALCIUM VITAMIN D VITAMIN B-12





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What did you already know?

What is new or surprised you?

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Lactose or Dairy Intolerance

A Guide for People Who Have Trouble Digesting Milk or Milk Products

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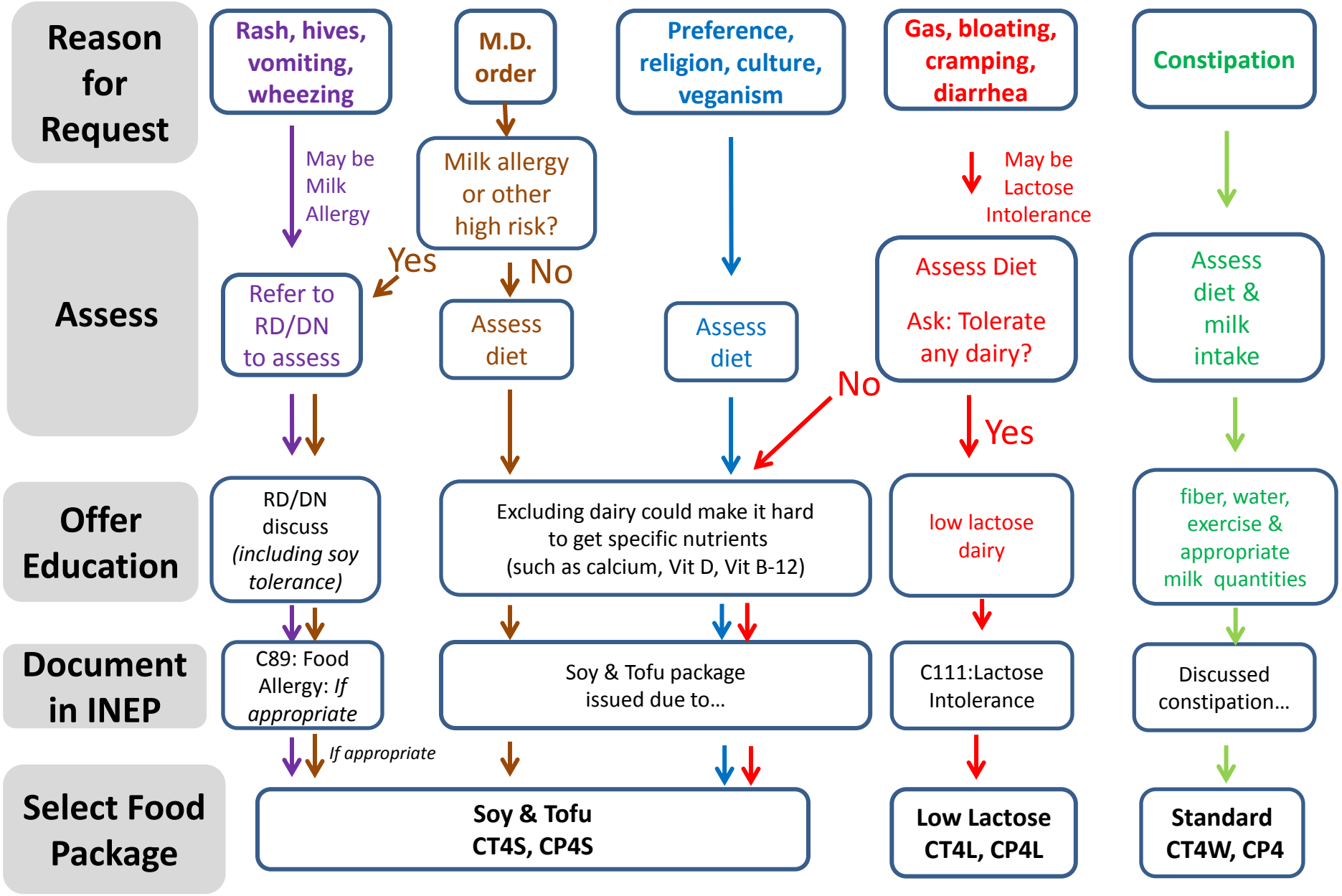
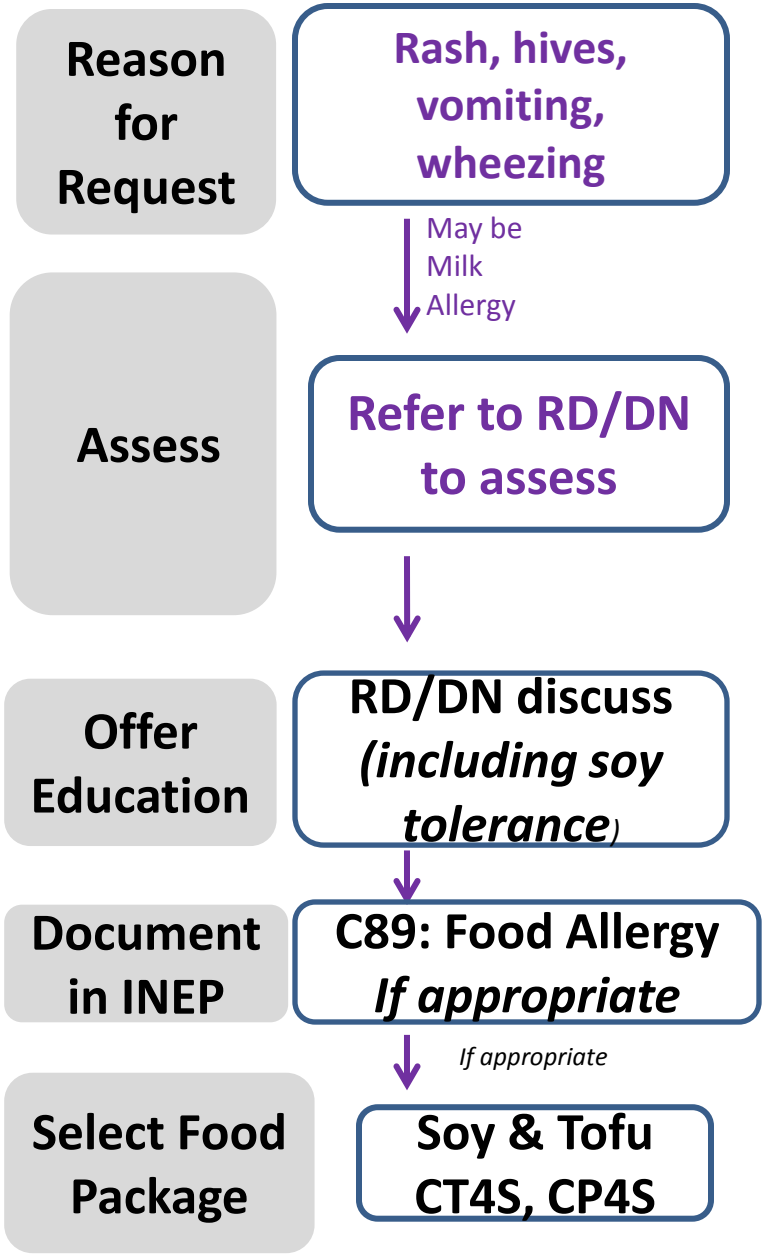
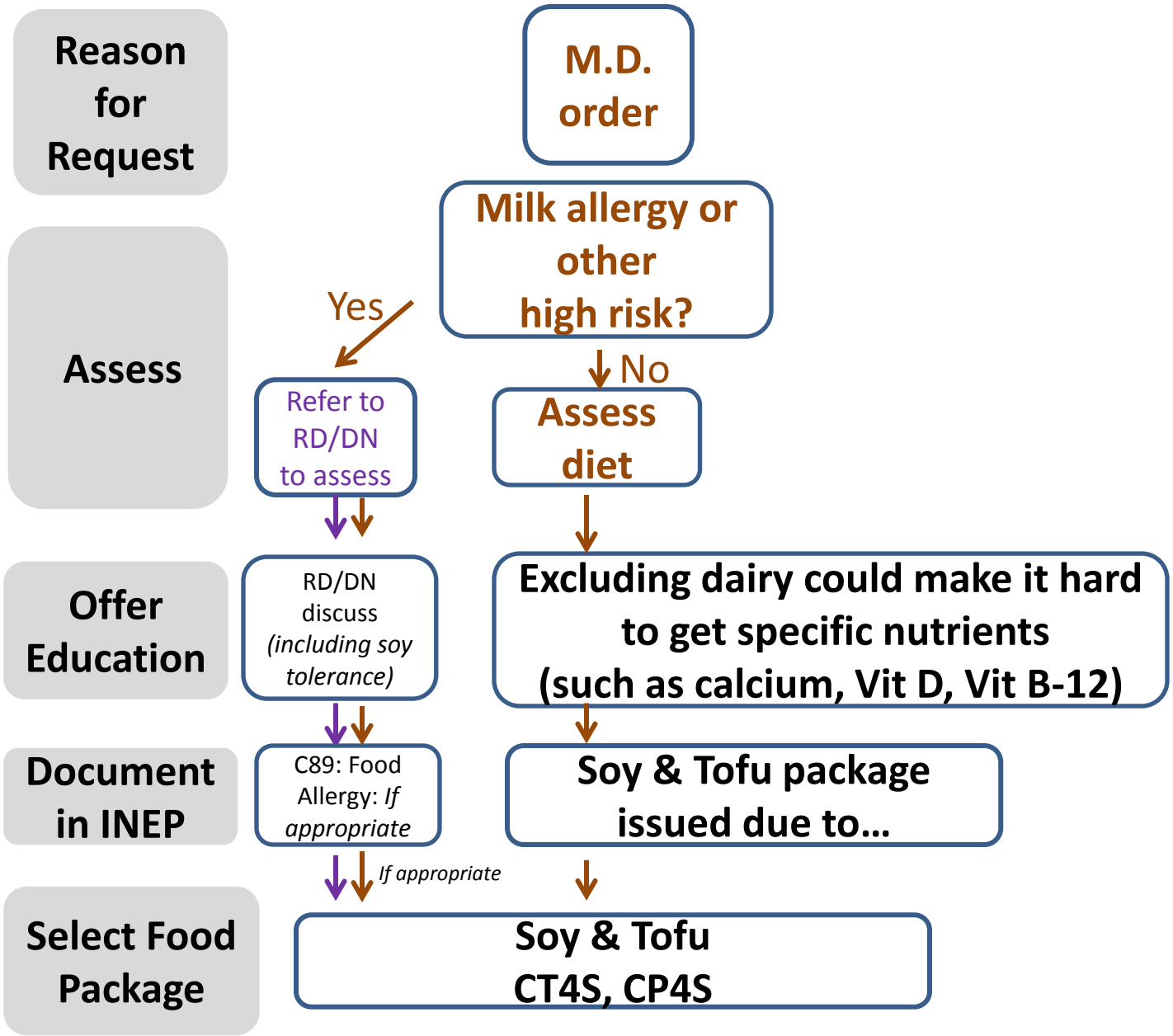
Choosing the Right Milk



Rash, hives, vomiting, wheezing



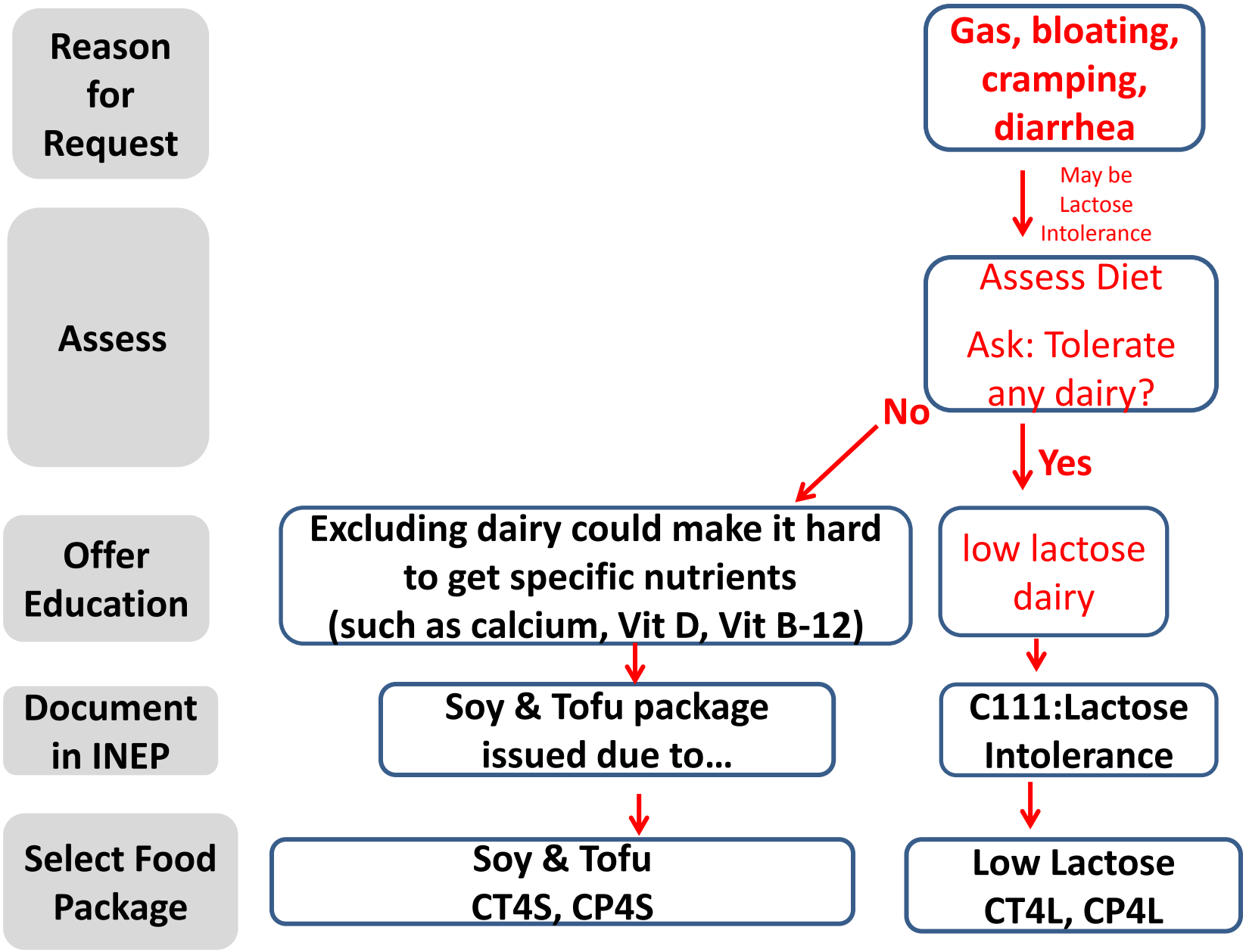
M.D. order


Reason for Request
Assess
Offer Education
Document in INEP
Select Food Package
M.D. order
Milk allergy or other high risk?
Yes
No
Refer to RD/DN to assess
Assess diet
RD/DN discuss (including soy tolerance)
Excluding dairy could make it hard to get specific nutrients (such as calcium, Vit D, Vit B-12)
C89: Food Allergy: If appropriate
Soy & Tofu package issued due to…
If appropriate
Soy & Tofu
CT4S, CP4S

Preference, religion, culture, veganism

Reason for Request	Preference, religion, culture, veganism
Assess	Assess diet
Offer Education	Excluding dairy could make it hard to get specific nutrients (such as calcium, Vit D, Vit B-12)
Document in INEP	Soy & Tofu package issued due to…
Select Food Package	Soy & Tofu CT4S, CP4S

Gas, bloating, cramping, diarrhea



Constipation

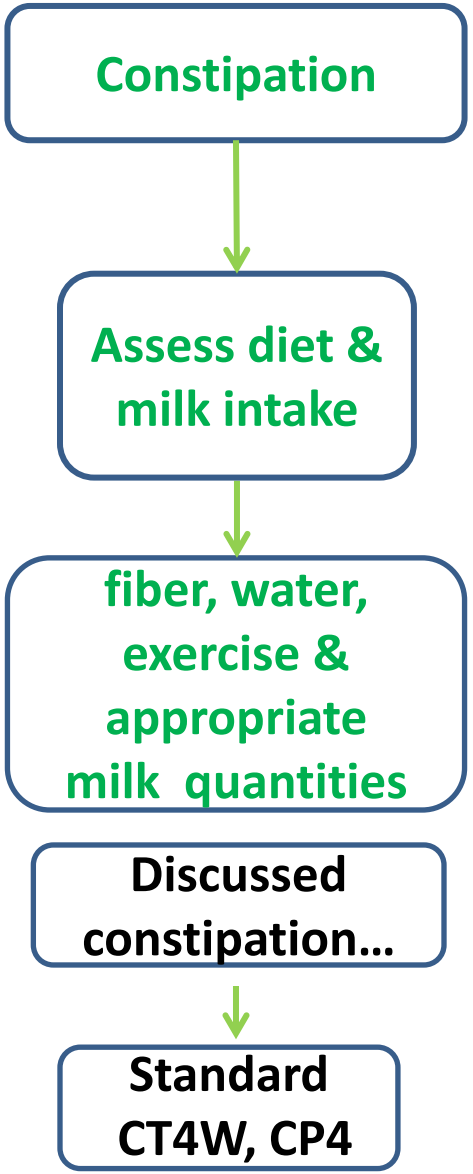
Reason for Request

Assess

Offer Education

Document in INEP

Select Food Package



Questions

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Practice

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State of California—Health and Human Services Agency

California Department of Public Health—WIC Program

Pediatric Referral

WIC Agency:

WIC ID#:

SECTION I: ***Complete this section to assist the patient with WIC eligibility, WIC services, and appropriate referrals. Whenever a therapeutic formula is prescribed, complete both Sections I and II.***

PATIENT NAME: (First) (Last)				DATE OF BIRTH:
CURRENT HEIGHT/LENGTH: (within 60 days) inches	CURRENT WEIGHT: (within 60 days) lbs oz	CURRENT BMI: (within 60 days) BMI percentile: %	MEASUREMENT DATE:	BIRTH WEIGHT / LENGTH: lbs oz / inches

HEMOGLOBIN OR HEMATOCRIT TEST is required every 12 months when normal and every 6 months when abnormal.

Hemoglobin (gm/dl) or Hematocrit (%)	Lab Result Date

LEAD TEST (recommended at 1-2 years of age): _____ mcg/dL

IMMUNIZATIONS are up-to-date:

☐ Yes ☐ No ☐ Not available

BREASTFEEDING ASSESSMENT (birth to 12 months):

☐ Fully breastfeeding ☐ Never breastfed

☐ Feeding breastmilk & formula ☐ Discontinued breastfeeding

Date: _____

SOY REQUEST FOR CHILD: *To substitute soy milk & tofu for cow's milk & cheese, check or write a condition below:*

☐ Cow's milk protein allergy ☐ Severe lactose intolerance

☐ Vegan ☐ Other: _____

COMMENTS:

HEALTH PROFESSIONAL NAME		MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP
HEALTH PROFESSIONAL SIGNATURE		
PHONE NUMBER	TODAY'S DATE	

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Pediatric Referral

WIC Agency:

WIC ID#:

ete this section to assist the patient with WIC eligibility, WIC services, and appropriate referrals.
ver a therapeutic formula is prescribed, complete both Sections I and II.

(First)	(Last)	DATE OF BIRTH:

H: inches	CURRENT WEIGHT: (within 60 days) lbs oz	CURRENT BMI: (within 60 days) BMI percentile: %	MEASUREMENT DATE:	BIRTH WEIGHT / LENGTH: lbs oz / inches

R HEMATOCRIT TEST is required every 12 months when normal
hs when abnormal.

(gm/dl) or Hematocrit (%)	Lab Result Date

mended at 1-2 years of age): _____ mcg/dL

are up-to-date:

☐ Not available

BREASTFEEDING ASSESSMENT (birth to 12 months):

☐ Fully breastfeeding ☐ Never breastfed
☐ Feeding breastmilk & formula ☐ Discontinued breastfeeding
Date: _____

SOY REQUEST FOR CHILD: *To substitute soy milk & tofu for cow's milk & cheese, check or write a condition below:*

☐ Cow's milk protein allergy ☐ Severe lactose intolerance
☐ Vegan ☐ Other: _____

L NAME

L SIGNATURE

TODAY'S DATE

MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP

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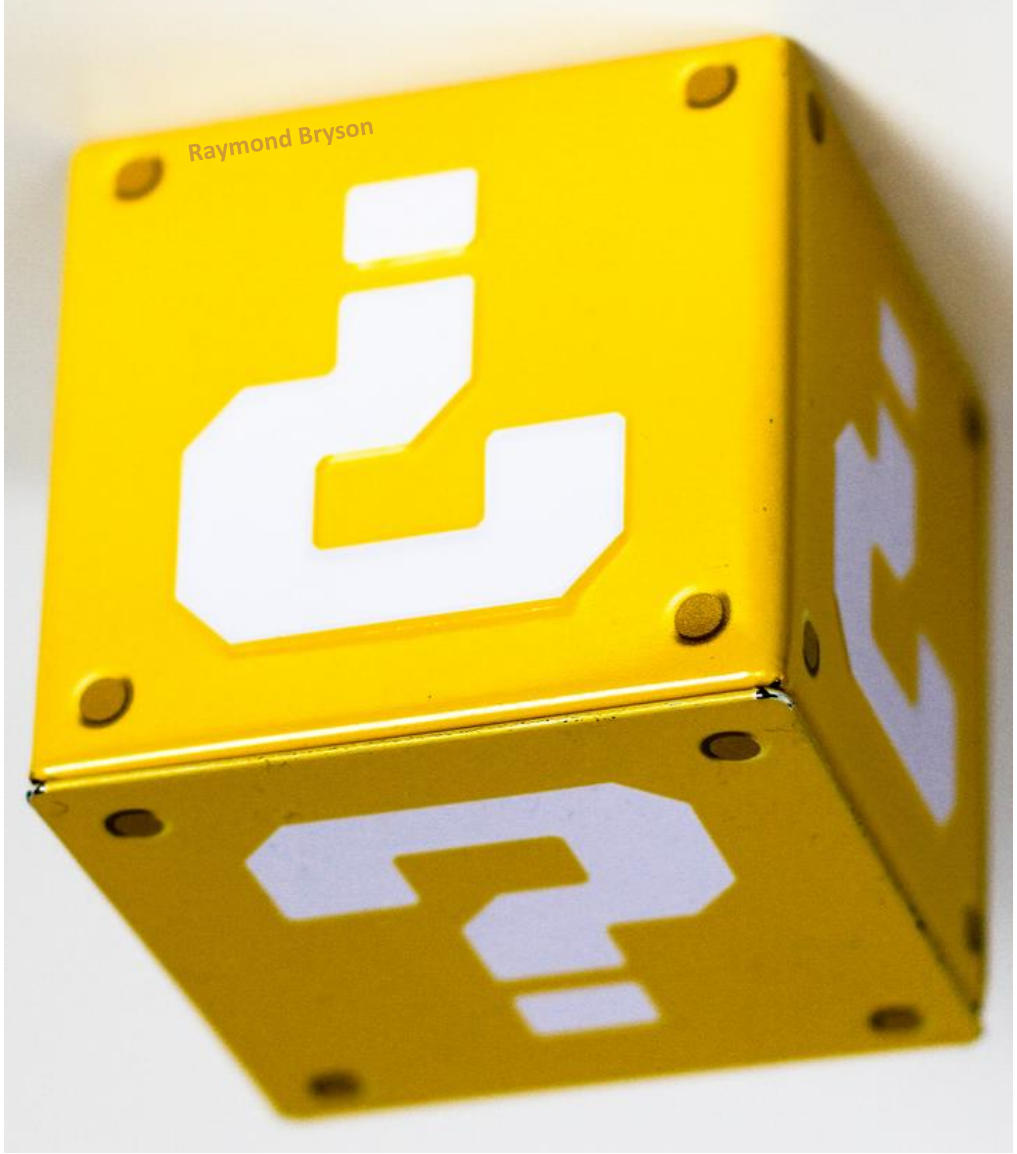
Questions



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Taste Test

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