

Cow's Milk Protein Allergy (CMPA)

Diagnosis and Management in Infants

This guidance has been developed by Consultant Paediatricians from Royal United Hospitals Bath NHS Foundation Trust (RUH), Great Western Hospitals NHS Foundation Trust (GWH) and Salisbury Foundation Trust (SFT) and Paediatric Dietitians from GWH, RUH & SFT in conjunction with the local Medicines Management Team.

The guidance is designed to be used by all health care professionals involved in the care of infants and young children with suspected Cow's Milk Protein Allergy (CMPA).

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Introduction to Diagnosis and Management in Infants

Cow's milk allergy (CMA), also termed cow's milk protein allergy/CMPPA, is common in infancy and usually resolves in the first few years of life. Symptoms can be vague and overlap with normal infant behaviour or other conditions, so careful assessment is essential. The aim is to relieve symptoms promptly without over-diagnosing CMA or continuing unnecessary exclusion diets.

Although cow's milk is specified, other mammalian milks such as sheep and goat milk have similar proteins and are therefore also expected to cause symptoms.

Non-IgE mediated Allergy (delayed):

- Most infants with milk allergy have non-IgE milk allergy
- Non-IgE milk allergy is also termed 'delayed onset' or type 2 allergy
- Non-IgE allergy is sometimes referred to as milk intolerance although this term can include other non-allergic symptoms from milk
- Symptoms occur between 2-48 hours or longer after exposure
- Mechanism uncertain but thought to occur due to T-cell activation and localised antibodies in the gut or other tissues. There are no accurate laboratory tests available for clinical use to diagnose non-IgE allergy.

IgE mediated Allergy (immediate):

- A smaller group of infants have IgE-mediated, sometimes termed 'acute onset' or type 1 allergy
- Symptoms usually occur within minutes, sometimes up to 2 hours after exposure
- Symptoms include urticaria, swelling, difficulty in breathing/wheeze, collapse

Symptoms which could be due to mild milk allergy are common in otherwise well infants and those with other diagnoses so *there is a risk of overdiagnosis of milk allergy*. There should however be increased suspicion of milk allergy in infants with multiple, persistent or treatment-resistant symptoms, particularly if they have significant eczema or a family history of atopy.

Examples of when to do a trial of milk exclusion include reflux causing the infant distress and not responding to smaller feeds & feed thickeners; eczema not responding to frequent emollients +/- hydrocortisone.

There is overlap between the symptoms of non-IgE and IgE related milk allergy but an 'allergy focused history' can help to distinguish the two groups (see **NICE guideline QS118** for further information)

Differentiation of the two groups is important as management is different

Allergy-focused history

Questions which may be helpful:

Milk feeds:

Was/is the child breast-fed? duration / partial / exclusive?

If exclusively breastfed: maternal dietary intake / foods?

If formula/mixed: age when formula / milk introduced, which formula milk?

Dietary history:

What food groups are eaten and any reaction(s)?

Appetite / do they eat well / enjoy food?

Any food(s) avoided?

Weight gain:

History of failure to gain weight?

Family history, ask if

Parents or siblings have allergic disease e.g. asthma, hay fever

Either parent avoids certain foods: if 'yes', why?

Symptoms and reactions:

What are the symptoms of concern?

What is their severity? Ask for a thorough description of the most recent reaction. Ask about age of onset of symptoms / frequency / *reproducibility* of reaction(s)

Management of previous reactions to food:

Did symptoms resolve without specific / medical intervention?

Medication given / which route / time from treatment to recovery

It's important that documentation of the type of cow's milk protein allergy is listed on medical records and referrals to the local paediatricians and dietetic teams.

Initial management principles

If a milk allergy is suspected:

- Start a **strict milk-free diet for 2–4 weeks** (more information to be found below).
- If symptoms are **severe** or **suggest IgE-mediated allergy**, continue milk exclusion and **refer to local paediatric team for further assessment and possible allergy testing**. Prescribe/advise antihistamine for acute symptoms. Actively treat any eczema and refer to dermatology if severe.
- Diagnosis of **non-IgE milk allergy** requires **both**:
 1. **Exclusion diet** for 2-4 weeks leading to symptom improvement

AND

 2. **Reintroduction challenge** to confirm or rule out milk allergy.
- Document clearly if IgE or Non-IgE is suspected.

Milk exclusion diet trial

Exclusively breast-fed infants: This is the gold standard, and appropriate support should be provided to parents to enable them to continue to breast feed. Exclude milk from maternal diet for 2-4 weeks and advise a suitable vitamin D (10micrograms daily) and calcium supplement.

Formula fed infants: Under 12 months prescribe hypoallergenic formula. Older children can use commercial milk-free toddler milks eg Alpro® Soya Growing Up milk.

Mixed feeding: Infant formula and all solid foods should be milk-free. Milk free substitutes can be used such as calcium fortified soya, coconut, oat-based products. If previously exclusively breast fed and symptoms did not occur until formula or solid food introduced, then maternal diet does not need to be milk-free. If breast feeding is only a small proportion of the infant's intake, then again maternal diet may not need to be milk-free.

Reintroduction challenge to diagnose non-IgE milk allergy:

- After 2–4 weeks of exclusion, gradually reintroduce cow's milk via formula/ food, or if exclusively breast fed, via maternal diet. The reintroduction is not a set time period, it continues until it is clear if symptoms have returned.
- For formula fed infants gradually increase the proportion of standard milk in each bottle of hypoallergenic formula starting with replacing one scoop/ounce in the first bottle of the day and increasing again the next day. For breast fed infants reintroduce milk and milk products into the maternal diet increasing the quantity over a period of a week.
- If original symptoms return → **milk allergy confirmed**. Do not need to continue the challenge for any set time, however, avoid over-interpreting day-1 symptoms. If symptoms are mild continue challenge for 1-2 weeks. If unclear may need to repeat the exclusion and rechallenge again.
- If new/different symptoms appear → unless suggests IgE mediated reaction, continue reintroduction for 1-2 weeks or repeat the exclusion and rechallenge again to clarify whether these symptoms are truly milk-related.
- The iMAP leaflet 'Early Home introduction to confirm the diagnosis of milk allergy' or similar local guidance should be given to family for further information. <https://gpifn.org.uk/imap/>

Antihistamine Medication

- If there are possible IgE-mediated symptoms, prescribe **antihistamine**, preferably non-sedating eg cetirizine to be given if acute symptoms. Cetirizine dose under 1 year 0.25mg/kg, max 2.5mg, twice daily if needed, very safe at all ages but off-licence under 2 years currently. Can obtain without prescription from 2years.
- Having antihistamine available can also increase family's confidence to introduce other allergens.
- See RUH Antihistamine leaflet online for more information:
https://www.ruh.nhs.uk/patients/services/clinical_depts/paediatrics/documents/patient_info/PAE063_Antihistamine_Allergy.pdf

Milk-Free Diet Guidance

Key points

- Milk allergy is a reaction to **milk protein**, not lactose, therefore **lactose-free products are not appropriate**.
- Avoid all cow's milk and milk-containing products. Avoid all other animal milks (goat, sheep, etc.) due to similar proteins. Product ingredient list will have the word 'milk' emphasised eg in bold.

Breastfed infants

Some infants react to small amounts of cow's milk protein in breastmilk.

Breastfeeding mothers:

- Should follow a **strict milk-free diet** during the exclusion trial (only required if symptoms occurred when exclusively breast feeding or breast milk a major part of infant's diet).
- Should not routinely avoid any other allergens eg egg, soya.
- Should take calcium and vitamin D supplement (and consider a supplement containing vitamin B12/iodine) while on a milk-free diet.
- *A milk-free diet is restrictive and can impact on nutrition – offer the iMAP leaflet for breastfeeding parents: <https://qpifn.files.wordpress.com/2019/10/imap-supporting-breastfeeding-factsheet.pdf>*
- Refer to a dietitian if avoiding multiple food groups.
- If continuing milk-free recommend retrying dairy **every 2–3 months** while breastfeeding to assess tolerance, starting with small amounts of cooked milk foods. Most will be able to have at least some highly cooked milk products in their diet. This will support nutrition for mothers and may help increase the chances of the infant's allergy resolving.

Formula choice

1. **Extensively hydrolysed formula (EHF)** is first-line under 12 months and suitable for ~90-95% of infants.
2. Transition gradually if needed due to taste differences.
3. Use amino-acid formula only for severe symptoms or EHF failure.

Weaning diet/ solid foods

- Use **fortified milk alternatives** to maintain nutrition.
- Direct family to local dietitian resources and Allergy UK.

Lactose Intolerance

Lactose intolerance is still commonly confused with a cow's milk allergy due to some potentially overlapping symptoms (diarrhoea, abdominal pain). Lactose intolerance does not cause rashes, eczema etc. Lactose free products are not appropriate for treating a milk allergy as they still contain the milk protein.

Key distinctions

- Lactose intolerance = **enzyme deficiency**, not an immune reaction.
- Most common in infants is **secondary lactose intolerance** after gastroenteritis.
- Primary lactose intolerance is rare in infants (presents with severe persistent diarrhoea from birth).

Breastfed infants

Breastmilk naturally contains high lactose. Maternal dairy avoidance **does not reduce lactose** in breastmilk.

Babies with bloating, green frothy stools, or vomiting after gastroenteritis may have temporary lactose overload related to high proportion of foremilk, not CMA. It would not usually be advised to stop breastfeeding during illness. The advice would be to continue breast feeding, unless symptoms are severe enough to warrant a review by paediatrician.

Useful resources:

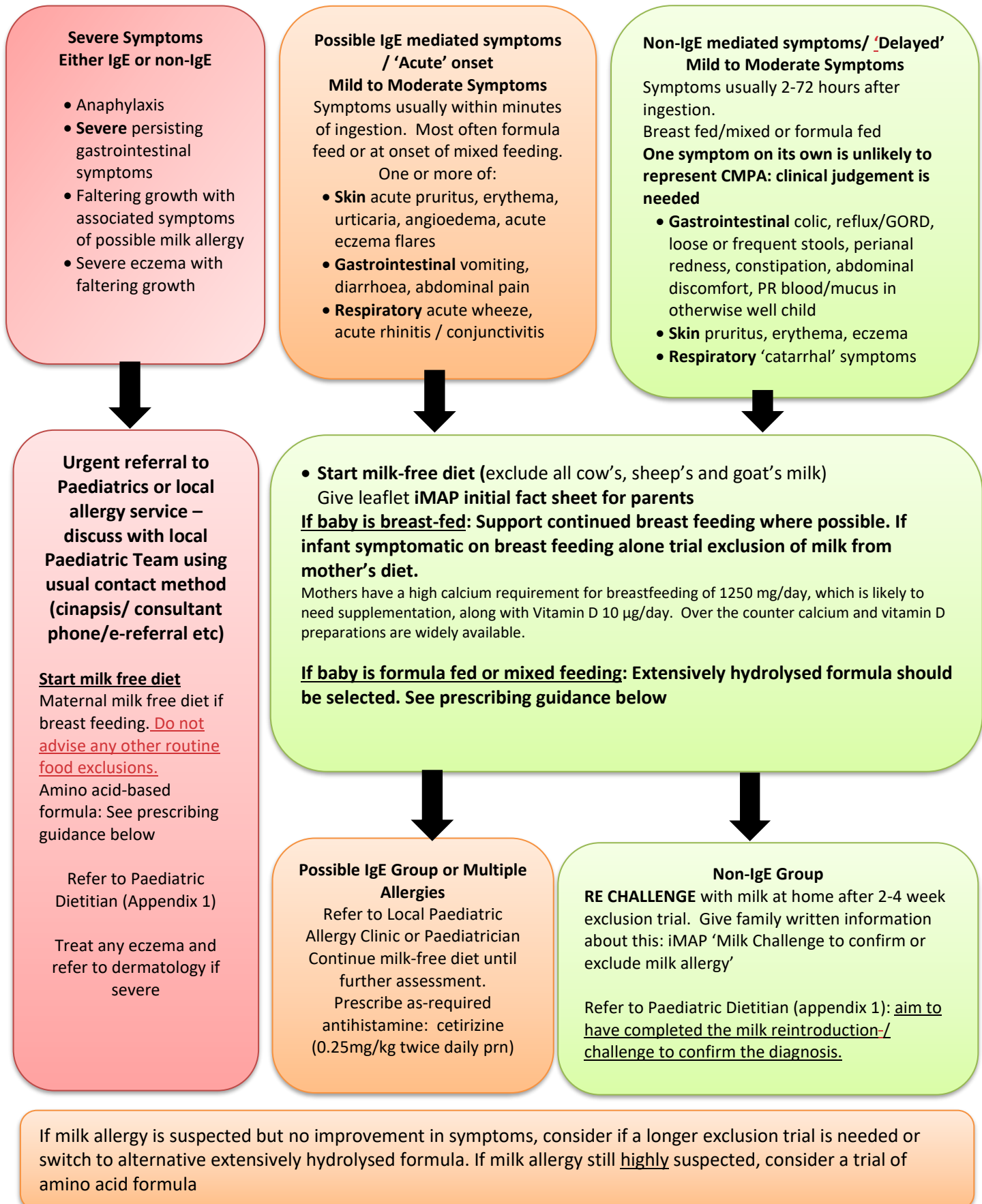
La Leche League: foremilk/hindmilk guidance <https://lila.org/breastfeeding-info/foremilk-and-hindmilk/>

Breastfeeding Network: lactose intolerance factsheet

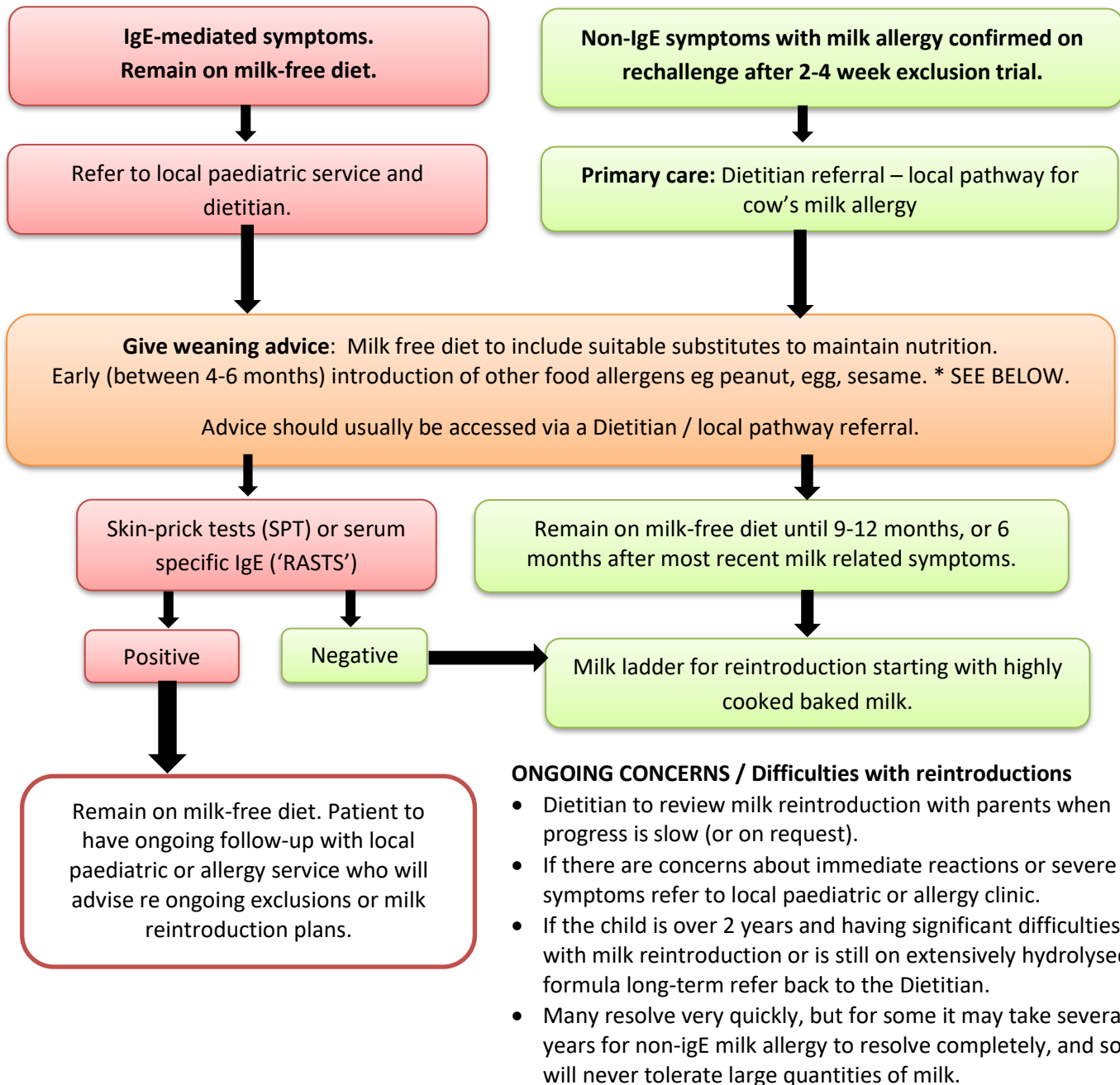
<https://www.breastfeedingnetwork.org.uk/factsheet/lactose-intolerance-and-breastfeeding/>

Algorithm: Initial Assessment of Suspected Cow's Milk Allergy in Infants

From the history put into one of the three groups below:



Ongoing management of cow's milk protein allergy



***Allergy prevention advice:** BSCAI/BDA Early Feeding Guidance www.bsaci.org/resources/resources/early-feeding-guidelines/ and SACN, 2018 "Feeding in the first year of Life"

Infants diagnosed with cow's milk allergy should be advised to introduce food allergens as soon as they start weaning foods. The earlier these foods can be introduced and importantly, kept in the diet regularly, the less likely the child is to develop a food allergy. The evidence is strongest for egg and peanut but felt to be similar for all allergens eg sesame, tree nuts, fish, wheat.

Early introduction of allergens from 4 months of age should be considered, particularly for those with ongoing eczema. This has been shown to significantly reduce further allergies developing, to be safe, and not to reduce breast feeding.

Types of Infant Formula and Milks

Extensively hydrolysed formula (eHF)

In extensively hydrolysed formula (eHF), cow's milk proteins are broken down into small peptides. eHF is suitable for most infants with cow's milk allergy. Families should be advised that these formulas have an unusual taste and smell, but most babies accept them, and brands do not differ significantly in palatability. Stool changes (e.g., green colour) are common and normal with eHF or amino-acid formulas.

If the infant struggles to take eHF, strategies include: mixing with expressed breast milk for breastfed infants needing supplements; mixing gradually with the usual formula for non-IgE cases; encouraging positive presentation of the milk; and using a lidded cup or bottle for older babies to reduce smell. If the first eHF remains unacceptable, seek dietetic advice or trial an alternative eHF.

Whey-based eHFs in the UK all contain lactose. Continuing lactose may help maintain tolerance and support the microbiome. Only infants with significant enteropathy may require a lactose-free option, which should be discussed with a paediatric dietitian.

Amino Acid formula

Amino acid-based formulas (AAFs) are made from individual amino acids and other components to create a nutritionally complete product, rather than being derived from cow's milk or other mammalian milks.

Only a small proportion of infants require an AAF. **These should be considered after two different extensively hydrolysed formulas (eHFs) have been tried, with referral to a paediatric dietitian.** AAFs are much more expensive than eHF.

They are first-line for infants with milk-induced anaphylaxis or significant enteropathy (e.g., persistent watery diarrhoea with faltering growth). They may also be used when breastfed infants needing top-ups have had marked symptoms from maternal dairy intake.

Prescribing guidance

Emphasize the need to strictly follow manufacturer's instructions when making up formula milk

	Status	Formula	Price*	Age
CMPA Extensively Hydrolysed Formula (eHF)	Green	SMA Althera/SMA Althera Advance	£11.04/400g	From birth
		Aptamil Pepti 1	£10.98/400g	From birth
		Nutramigen 1 with LGG	£12.92/400g	From birth
		Aptamil Pepti 2	£10.98/400g	6 months +
		Nutramigen 2 with LGG	£12.92/400g	6 months +
	Amber	Aptamil Pepti Syneo	£10.98/400g	From birth
		Arize	£15.89/400g	From birth
CMPA Amino Acid Formula (AAF)**	Green	Nutramigen Puramino	£22.98/400g	From birth
		Neocate LCP	£25.56/420g	From birth
		SMA Alfamino/SMA Alfamino Advance	£25.73/400g	From birth
	Amber	Neocate Syneo	£25.56/400g	From birth
		Neocate Junior	£41.23/400g	1 year +

KEY: Green
Prescribe First Line

Amber:
Prescribe at recommendation of Specialist/Dietitian

Note:

* Prices correct as of February 2026

** AAF should ONLY BE prescribed in the following instances:

1. First-line for infants with milk-induced anaphylaxis or significant enteropathy (e.g., persistent watery diarrhoea with faltering growth)
2. To be considered after two different extensively hydrolysed formulas (eHFs) have been tried, with referral to a paediatric dietitian

Quantities of formula to prescribe

When starting a specialist formula only prescribe 3 x 400g/450g tins as a trial in case there are tolerance issues

Age	Average infant formula intake / 24 hours	Total average amount per 24 hours	Tins per month required
0-2 months	90ml – 120ml (3-4floz) x 6-8 feeds	630 – 780 ml (21-26floz)	8 x 400g/450g tins 4 x 900g tin
3-6 months	180ml (6floz) x 5 feeds	900 – 1050ml (30-35floz)	12 x 400g/450g tins 6 x 900g tin
7-11 months	210ml (7floz) x 3 feeds	630ml (21floz)	8 x 400g/450g tins 3 x 900g tins
12-18 months*		300ml (10floz)	4 x 400g/450g tins 2 x 900g tins

*Prescriptions **should not** be issued for children over the age of 18 months unless a consultant paediatrician or paediatric dietitian request that it is continued.

Other dairy-free milks

Most milk substitutes are fortified with calcium (120mg per 100g) but check the 'organic' products and parents should be advised to read labels.

Milk Type	Suitable as a main drink <2 yrs?	Key Points	When to Use
Growing Up/Toddler Milks (12–36 months)	Yes	Fortified with vitamins, calcium, iodine. Higher protein than standard plant milks. Often suitable replacement from 12 months.	Preferred from 12–24 months if growth/diet concerns. Good transition from extensively hydrolysed formula (eHF).
Standard Soya Milk	Yes, if growing well	Adult soya milks can be used in cooking/cereal. Prefer toddler versions under 2 yrs.	If tolerated and no concerns about growth.
Standard Oat Milk	Yes, if growing well	Lower protein than soya. Barista versions higher in fat. Suitable if unable to tolerate soya or pea protein	Use in cooking/cereal; OK as main drink after 12 months if growth good.
Nut, Pea, Coconut, Hemp Milk	No (unless under specialist advice)	Usually too low in protein, calories and vitamins for under 2s	Small amounts in cooking only. Choose fortified versions.

Sheep & Goat Milk/Formula	No	Proteins are very similar to cow's milk so this is not suitable for cow's milk allergy	May be tolerated later during milk ladder/reintroductions in some non IgE cases
Lactose Free Milk/Formula	No	This contains cow's milk protein so not appropriate for cow's milk allergy	Only used for lactose intolerance
Rice Milk	No under 4 years	Standard rice milk is not recommended due to arsenic levels. Similac Arize (rice based hydrolysed formula) now available and safe for under 12 months	Avoid as main milk for under 4 years

Types of milk to suggest from 12 months of age

Most infants with cow's milk allergy can transition off specialist formula soon after 12 months if they tolerate soya-based milks or a toddler oat milk fortified with pea protein (e.g., *Alpro Growing Up*). From 6–9 months, encourage the use of fortified soya milk on cereal and soya yoghurts.

Infants with multiple food allergies (e.g., milk, soya, pea protein) or poor growth may require prescribed formula beyond 18 months and should continue under paediatric or dietetic care.

For all others, parents should be informed that prescriptions will end by 18 months, unless advised otherwise. Families can then choose from a wide range of suitable milk- and soya-free alternatives such as oat, nut, or coconut milks—preferably calcium-fortified.

If the child struggles with the taste of new milk, parents can mix small amounts of the new milk with the prescribed formula to ease transition. Vanilla essence or dairy-free milkshake powders may help initially (with dental hygiene advice). If still using a bottle, this transition period is a good opportunity to move to a cup or beaker.

Vitamin Supplements

Nationally it is advised that all children under five years are given a vitamin supplement to provide vitamins A and D if they are breast fed or drinking less than 500mL of formula per day. These can be purchased by the parent, or they may be entitled to Healthy Start Vitamins (www.healthystart.nhs.uk).

All breastfeeding mothers should take a vitamin D supplement, and if milk-free should have calcium and consider vitamin B12 in addition (there are specific breast feeding supplements or an A-Z preparation)

From 5 years national advice for everyone is to consider a vitamin D supplement in autumn and winter months at all ages (10micrograms/day).

Other milk related conditions

There are related milk allergy related conditions which may require ongoing paediatric or gastroenterology input. These include food protein induced enteropathy syndrome (FPIES), eosinophilic oesophagitis and infantile proctocolitis.

Infant proctocolitis: this presents with small amounts of PR bleeding in infants, often breast fed. If the baby is otherwise well and is gaining weight it is reasonable to observe without doing any milk exclusion for 2-4 weeks as the condition will often settle spontaneously. If the PR bleeding continues for more than 2-4 weeks start a milk exclusion as above and refer to paediatrics.

FPIES: This is a type of non-IgE allergy that typically presents with profound vomiting 2-4 hours after the food. The baby/child may be very lethargic during the episode and in severe cases can be systemically unwell with acidosis. If milk is suspected as a cause start milk exclusion and refer to paediatrics urgently. FPIES.org <https://www.fpiesuk.org/> has very useful information including management plans.

Eosinophilic oesophagitis: This is a rare condition that can present with persistent swallowing difficulties and vomiting. It is diagnosed by endoscopy and management will be advised by paediatric gastroenterology and specialist dietitians but often involves milk exclusion.

Milk 'Ladders'

Milk ladders are used to gradually reintroduce milk into the diet of children with resolving non-IgE-mediated milk allergy, and they differ from the initial diagnostic milk challenge. Their purpose is to safely return the child to a normal diet, and evidence shows that regular inclusion of small amounts of baked milk can support the development of tolerance. **A referral to a dietitian should be completed during this phrase.**

If symptoms occur during the ladder, families should step back to the last tolerated food rather than stopping completely. For ongoing gastrointestinal or eczema symptoms, foods may need to be given in smaller amounts or less frequently (2–3 times per week).

When reviewing progress, it is more helpful to ask which specific foods have been tried, as ladder steps vary across resources.

In primary care, the iMAP 6-step ladder is commonly used for non-IgE milk allergy, though quantities can be adapted depending on sensitivity. Some dietitians use the original 12-step version. iMAP materials are available at <https://gpifn.org.uk/imap/>.

Other ladders exist based on clinician preference, cultural dietary needs (e.g., egg-free or Asian-food ladders), or for those with resolving IgE-mediated milk allergy, which progress more slowly. These slower ladders—such as the Wessex crumb ladder—may also be suitable for non-IgE cases struggling to progress. The choice of ladder should be guided by a paediatric dietitian, paediatrician, or allergy specialist.

References

The Milk Allergy in Primary Care (MAP) Guideline 2019: <https://gpifn.org.uk/imap/>

Diagnosis and management of non-IgE-mediated cow's milk allergy in infancy - a UK primary care practical guide, C. Venter, T. Brown, N. Shah, J. Walsh and A. Fox, Clinical and Translational Allergy 2013, 3:23
<http://www.ctajournal.com/content/3/1/23>

BNFc online – <https://bnfc.nice.org.uk/>

NICE guidance CG116 Food allergy in children and Young People February 2011 Last update 2018
<http://www.nice.org.uk/cg116>

NICE Cow's milk allergy in children: Updated 2025 [Cow's milk allergy in children | Health topics A to Z | CKS | NICE](#)

BSACI guideline for the diagnosis and management of cow's milk allergy, D. Luyt, H. Ball, N. Makwana, M. R. Green, K. Bravin, S. M. Nasser and A. T. Clark, Clinic & Experimental Allergy, 2014: 44, 542-672
<https://onlinelibrary.wiley.com/doi/pdf/10.1111/cea.12302>

ESPGHAN Position Paper on the Diagnosis, Management, and Prevention of Cow's Milk Allergy. Vandenplas Y, Broekaert I, Domellöf M, Indrio F, Lapillonne A, Pienar C, Ribes-Koninckx C, Shamir R, Szajewska H, Thapar N, Thomassen RA, Verduci E, West C. J Pediatr Gastroenterol Nutr. 2024 Feb;78(2):386-413.

<https://www.bsaci.org/resources/resources/early-feeding-guidelines/>

Wessex IgE milk allergy home introduction and secondary care guidance: accessed 2025
<https://www.piernetwork.org/>

Appendix 1. Referral information and contact details

Please refer to the most local service as milk allergy is a long term condition requiring multidisciplinary team input and liaison with community services.

Bath and NE Somerset

Paediatric Dietitians

Nutrition & Dietetic Services,

Royal United Hospitals Bath NHS Foundation Trust Combe Park Bath BA1 3NG

Email referrals to: ruh-tr.paediatricdieteticreferrals@nhs.net

Please note that this email address is for referrals only.

If the referral is urgent, please telephone the Dietetic Department on **01225 826449**.



General Paediatric Team: GP referrals via e-RS or contact using cinapsis system

Paediatric Allergy Clinic Royal United Hospital (RUH): GP referrals via e-RS or enquires via cinapsis

ruh-tr.paediatricallergy@nhs.net

This mailbox is specifically for queries from healthcare professionals. GP referrals should go via E-referral service or cinapsis

Swindon

GWH Paediatric Dietitians refer via email

gwh.paediatricdieteticreferrals@nhs.net



General Paediatric Team (including allergy referrals): GP referrals via e-RS or contact using cinapsis system

Wiltshire

Wiltshire Nutrition and Dietetics Service (HCRG) <https://bswcommunityservices.co.uk/services/dietetics-service/>

Paediatric Dietitians:

Referrals are accepted from health professionals to include Paediatricians, Community Paediatricians, GPs, Health Visitors and other Wiltshire Care community health professionals.

Tel: 0300 247 0204

Email: wilts.dietetics@hcrccaregroup.com



Salisbury

Salisbury Hospital: Main Switchboard: 01722 336262

General Paediatric Team (including allergy referrals): GP referrals via e-RS or contact using cinapsis system

Somerset

Paediatric dietitians

GP's and health care professionals can refer directly to the Paediatric community dietetic service using the downloadable referral form online <https://www.somersetft.nhs.uk/nutrition-and-dietetics/referring-to-community-dietetic-services/>

Family and carers can also be signposted to the self-management website www.patientwebinars.co.uk where appropriate

Appendix 2: Links for Patient information leaflets

The GP infant feeding network hosts the all the iMAP leaflets: <https://gpifn.org.uk/imap/>

iMAP initial fact sheet for parents

https://gpifn.files.wordpress.com/2019/10/imap_patient_factsheet_original.pdf

iMAP leaflet for breastfeeding parents

<https://gpifn.files.wordpress.com/2019/10/imap-supporting-breastfeeding-factsheet.pdf>

iMAP Early home reintroduction (milk challenge information sheet)

[The Early Home Reintroduction to Confirm the diagnosis of Cow's milk allergy](#)

BDA Calcium Food Fact sheet

<https://www.bda.uk.com/resource/calcium.html>

BSACI/ BDA Early feeding guidance

Preventing food allergy in your baby: Early feeding guidance leaflet

<https://www.bsaci.org/resources/resources/early-feeding-guidelines/>

The RUH website has a number of related leaflets: can be downloaded by families and GPs from the RUH external website (please note a number of these have not been reviewed recently but are likely to still be relevant – they will be updated in due course) <https://www.ruh.nhs.uk/>

- Milk allergy diagnosis for babies (how to safely do a milk free trial in babies)
- Milk free diet factsheet
- Reintroduction of milk into your child's diet
- Diet and eczema
- Antihistamines

Allergy UK

Allergy UK has an excellent range of resources about both Ige and non-IgE mediated milk allergy.

[Cow's Milk Allergy | Allergy UK | National Charity](#)

<https://www.allergyuk.org/information-and-support/support-for-your-child/allergy-in-childhood/cows-milk-allergy/>