C.B.S.

State Sponsored School and Summer Kosher Food Program
85 Suite F Tomlinson Road Huntingdon Valley, PA 19006
Phone: 215-938-0201/ FAX: 215-938-0205

ATTN.

All items with an * need to be filled out.

WRITE IN CAPITAL Letters ONLY.
If any item with an * is left blank, the application cannot be processed and will be returned.

Thank You ☺

C.B.S.

State Sponsored School and Summer Kosher Food Program
85 Suite F Tomlinson Road Huntingdon Valley, PA 19006
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Attention Parents:

Please give your RECORD NUMBER #, if you receive SNAP Benefits. NOT your ACCESS Card number that starts with 600??..

This will guarantee FREE meals for your child, and you will not be billed.

Please give your

County Code (2 digits) and
Record number (7 digits).

Sample

51-0123456
09-0123456
23-0123456
46-0123456

Please look up the number on your County Assistance Office paperwork or call your local office.

If you have any questions, please feel free to call Rilana @ **215-938-0201**.

Your CBS Staff

C.B.S.

State Sponsored School and Summer Kosher Food Program
85 Suite F Tomlinson Road Huntingdon Valley, PA 19006
Phone: 215-938-0201/ FAX: 215-938-0205

CACFP SAMPLE LETTER to Households-Pricing Institutions

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **C.B.S. State Sponsored Food Program** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture?s (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. Your child(ren) may buy lunch for **$ 2.00**, breakfast for **$ 1.00**, and snack for **$ 0.50**. Your child(ren) may also receive meals free or at a reduced price of **$ 0.40** for lunch, **$ 0.30** for breakfast, and **$ 0.15** for snack. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. Do I need to fill out a Meal Benefit Form for each of my children in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: *C.B.S. State Sponsored Food Program 85 Tomlinson Road Huntingdon Valley, PA 19006*, 215-938-0201.**

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.

3. Who can get reduced price meals? Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed, by source, each household member received last month. If last month?s income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month?s income as a basis to make this projection. If your household?s income is equal to or less than the amounts indicated for your household?s size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, or FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact: ***C.B.S. State Sponsored Food Program 85 Tomlinson Road Huntingdon Valley, PA 19006*,**

215-938-0201.

9. We are in the military; do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member?s income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

10. Will the information I give be verified? There may be a possibility that your application may be selected for verification. We may ask you to send written proof to verify the information you submitted on the form. What if I disagree with the decision about the information I complete on this form? You should talk to your **C.B.S. State Sponsored Food Program.**

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **215-938-0201**.

Sincerely, **Your C.B.S. STAFF**

C.B.S.
85 Tomlinson Rd. Suite D
Huntingdon Valley, PA 19006
Phone: 215-938-0201

Instructions for Completing the CACFP Child Care Center Meal Benefit Income Eligibility Form

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children (max. 4 children per form) and household members.
Part 2: List the case number for any household members (including adults) receiving State SNAP or State TANF or FDPIR benefits.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are not necessary.
Part 6: Answer this question if you choose.

FOSTER CHILDREN HOUSEHOLDS, will follow these instructions:

A Meal Benefit Form is not required to be completed. Contact the center at *215-938-0201*; OR

If some of the children in the household are foster children:

Part 1: List all enrolled children (max. 4 children per form) and household members. For any people, including children, with no income, you must check the ?No Income Box.? Check the box if the child is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call [your school, homeless liaison, migrant coordinator]. If not, skip this part.
Part 4: Follow these instructions to report total household income for this month or last month.

Column A ? Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B ? Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received ? weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
Box 2: List the amount each person got for the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran?s (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker?s Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if she/he doesn?t have one.

Part 6: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children (max. 4 children per form) and household members. For any people, including children, with no income, you must check the ?No Income Box.?

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income for this month or last month.

Column A ? Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B ? Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received ? weekly,

every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got for the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran?s (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker?s Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if she/he doesn?t have one.

Part 6: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household size	Yearly
1	$22,311
2	$30,044
3	$37,777
4	$45,510
5	$53,243
6	$60,976
7	$68,709
8	$76,442
Each additional person:	+$7,733

For Reduced Price Meals 2017-2018

These guidelines are in effect from July 1, 2017 to June 30, 2018.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. ?In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.?

C.B.S.

State Sponsored School and Summer Kosher Food Program
85 Suite F Tomlinson Road Huntingdon Valley, PA 19006

ARE YOUR FORMS COMPLETE???

- **Daycare Signature**
- **Parent Signature (2 forms)**
- **TANF Case Number (all 9 digits)**
- **Hours of Care**
- **Daily Expected Meals**

Together **E**very one **A**ccomplishes **M**ore!
Thanks ☺

Your CBS Staff
215-938-0201 Phone

Child and Adult Care Food Program **Child Care Center Meal Benefit Income Eligibility Form** 2017-2018

LITTLE SCHOLARS ACADEMY 5000005539 | 2010 Rhawn Street, Philadelphia, Pennsylvania 19152

Fill out all FIELDS (*) in PRINT with Black Ink. If left blank ? forms will NOT be processed ? child(ren) will NOT be placed on roster to receive meals.

Part 1. All Household Members

*Names of **Enrolled** Child(ren) in this daycare: Kids attending THIS location FIRST LAST	CHECK IF A **FOSTER CHILD** (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	*CHECK IF NO INCOME	*AGE:
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Names of all Household Members (First, Middle Initial, Last) Total # number of people in your house* _____

→*	☐	*☐	
→*	☐	*☐	
→*	☐	*☐	
→*	☐	*☐	
→*	☐	*☐	

***Part 2. Benefits: Do you receive SNAP Benefits? ☐ YES ☐ NO (check one)**

If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3.

*NAME:_____ CASE NUMBER: * ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call [Your center director, Homeless Liaison, Migrant Coordinator at Phone #] Homeless ☐ Migrant ☐ Runaway ☐

Part 4. Total Household Gross income and how often it was received

e.g. weekly, bi-weekly, twice a month, month

A. Name (List ONLY household members with income)	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) Jane Smith	$ Gross Income/How often	$ Gross Income/How often	$ Gross Income/How often	$_____/_____
→*	$*_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 or 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the ?I do not have a Social Security Number? box.** (See Privacy Act Statement on the back of this page.) «Center_Phone_»

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

→*Sign Here: _____ →*Print Name: _____ *Date: _____

*Address: _____ *Phone Number: _____

*City: _____ *State: _____ *Zip Code: _____

Last four digits of Social Security Number: XXX-XX-→* __ __ __ __ ❑ I do not have a Social Security Number

Part 6. Participant?s ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:		
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian	❑ American Indian or Alaska Native	
	❑ White	❑ Native Hawaiian or Other Pacific Islander	❑ Black or African American

Don?t fill out this part. This is for official use only. C.B.S. USE ONLY!!! DO NOT WRITE BELOW THIS LINE!

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: _____ Eligibility: Free_____ Reduced_____ Denied (Paid)_____ Date Withdrawn: _____

Reason for Denied: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official?s Signature: _____ Date: _____

Confirming Official?s Signature: _____ Date: _____

Follow-up Official?s Signature: _____ Date: _____

Code:_____ ☐Renewal ☐Code Change ☐Change Daycare

Child Enrollment Form 2017-2018

Sponsoring Organization:	Center Information:
CBS State Sponsored Food Program 85 Tomlinson Road Suite D Huntingdon Valley, Pa 19006 Phone: 215-938-0201	**LITTLE SCHOLARS ACADEMY 5000005539** 2010 Rhawn Street, Philadelphia, Pennsylvania 19152 (215) 342-9500

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

REQUIRED: ➔ ***Signature** _____ ***Date** _____
Parent/Guardian

REQUIRED: ➔ ***Signature** _____ ***Date** _____
Center Administrator/Home Provider

***Normal Hours of Care** (write in times)*

Monday ? Friday Drop Off: _____ Pick Up: _____
* If more than 8 hours of care per day, please attach an explanation to this form.

Saturday Drop Off: _____ Pick Up: _____Sunday Drop Off: _____Pick Up: _____

➔* **DO NOT LEAVE BLANK! Daily Expected Meal Service Participation** (please check box-**regardless of age-DO NOT LEAVE BLANK!**)
Breakfast ☐ | AM Snack ☐ | Lunch ☐ | PM Snack ☐ | Supper ☐ | Eve Snack ☐

Is this child of school age? ___Yes ___No If yes, will additional meals be **provided by parents** when school is not in session? ___Yes ___N If yes, please specify the meal: ___Breakfast ___Lunch ___Snack ___Supper

---

***Child?s FIRST NAME:**

***Child?s LAST NAME:**

***Child?s Date of Birth:**

If under 12 months, in addition, need Infant Supplement form (0 to 12 months) 3pages TOTAL

*MM / DD / YY

***Address:**

***Apt.# or Floor** ***City** ***State** ***Zip Code**

***PARENT/GUARDIAN:**

(E-mail):

Parental Contacts: This child care facility participates in the Child and Adult Care Food Program. **C.B.S. State Sponsored Food Program** is the sponsor. In order to receive federal funds, representatives of the sponsoring organization may contact you to verify your child?s participation. Please indicate what time and method of contact you prefer:

***Telephone (home):** **Telephone (work):**

_____Day _____Evening _____Time
_____Letter _____Telephone (home) _____Telephone (work)

?In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.?

For Sponsor Use Only

Child enrolled on:_____ Child withdrew on:_____

C.B.S.

State Sponsored School and Summer Kosher Food Program
85 Suite F Tomlinson Road Huntingdon Valley, PA 19006

CHILD AND ADULT CARE FOOD PROGRAM
INFANT ENROLLMENT FORM 2017-2018
12 MONTHS (OR YOUNGER)

Directions: This enrollment supplement must be completed for all infants in care at the time of enrollment to determine responsibility for providing infant formula as part of the Child and Adult Care Food Program (CACFP). Please have the parent sign and date two forms. Send one to your sponsoring organization and keep the other as part of the infant?s enrollment file.

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

*Infant Name:_____ *Date of Birth:_____

Center Information:	
LITTLE SCHOLARS ACADEMY 5000005539 2010 Rhawn Street, Philadelphia, Pennsylvania 19152 (215) 342-9500	☐ Need Income Form ☐ Need Enrollment Form

CBS will offer the following iron-fortified formula: Berkley & Johnson

*PARENT CHOICE: (Please check one)

☐ CBS will furnish the Berkley & Jensen infant formula.

☐ The Parent will furnish the infants formula/Breast milk.

_____
Indicate Type of Formula or Breast Milk

If the above type of formula does need meet the CACFP meal pattern requirements, Please attach a copy of the physician?s medical statement recommending this type of formula.

Are there any special circumstances or conditions indicated by infant?s physician? _____

_____

As the parent of the above named-name child, I understand that I may change my decision regarding furnishing infant formula and/or food with proper notice.

REQUIRED: ➔ *_____ *_____
Parent?s Signature Date

REQUIRED: ➔ *_____ *_____
Signature of Center Director Date

C.B.S.

State Sponsored School and Summer Kosher Food Program
85 Suite F Tomlinson Road Huntingdon Valley, PA 19006

Letter for Families DECLINING C.B.S. State Sponsored Food Program 2017-2018

Directions: This supplement form must be completed if you choose to **DECLINE** the participation in the State Sponsored Food Program provided by C.B .S. Send one to CBS and keep the other as part of the child?s file in your center.

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

*Child?s Name:_____ *Date of Birth:_____

NOT FOR INFANTS 0-12months!

Center Information:
LITTLE SCHOLARS ACADEMY 5000005539
2010 Rhawn Street, Philadelphia, Pennsylvania 19152
(215) 342-9500

* ☐ **The Parent DECLINES and will furnish the child?s meals**.
Please check box!

HAND THIS IN, ONLY WHEN DECLINING!
(don?t send it with every enrollment/income form)

_____

As the parent of the above named-name child, I understand that I may change my decision with proper notice.

C

REQUIRED: ➔ *_____ *_____
Parent?s Signature Date

REQUIRED: ➔ *_____ *_____
Signature of Center Director Date

C.B.S.

State Sponsored School and Summer Kosher Food Program

85 Suite F Tomlinson Road Huntingdon Valley, PA 19006

Phone: 215-938-0201/ FAX: 215-938-0205

Medical Plan of Care for Child and Adult Care Food Program

(Children with Disabilities and Non-Disabling Special Dietary Needs) **PAGE 1 of 2**

The following child is a participant in the United States Department of Agriculture (USDA) Child and Adult Care Food Program.

? USDA regulations 7CFR Part 15B require substitutions or modifications in program meals for children whose **disability** restricts their diet and is supported by a statement signed by a **licensed physician**. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of ?disability.?

? The child care facility may choose to accommodate a child with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).

Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

*Child?s Name		*Date of Birth	F M
*Name of School/Center/Program **LITTLE SCHOLARS ACADEMY 5000005539** **(215) 342-9500**		*Grade Level/Classroom	
*Parent?s/Guardian?s Name		*Address, City, State, Zip Code	
* Home Phone ( ) -		* Work Phone ( ) -	

***Part 2: To be completed by Physician/Medical Authority** **Disability/Special Dietary Needs**

*Does the child have a **disability**? Yes □ No □

If Yes,

Please describe the major life notes affected by the disability.

*Does the child's disability affect their nutritional or feeding needs? Yes □ No □

*If the child **does not have a disability***, does the child have special nutritional or feeding needs? Yes □ No □

(*These accommodations are optional for child care facility to make)

If the child has a disability or special dietary/feeding need, please complete Part 3 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority

***Part 3:** To be completed by **Physician/Medical Authority**

Diet Order

***List any dietary restrictions, such as food allergies, intolerances or restrictions:**

***List specific foods to be substituted (Substitution cannot be made unless section is completed):**

*List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate ? All?.[1]

***Cut up/chopped into bite sized pieces:**

***Finely Ground:**

***Pureed:**

C.B.S.

State Sponsored School and Summer Kosher Food Program

85 Suite F Tomlinson Road Huntingdon Valley, PA 19006

Phone: 215-938-0201/ FAX: 215-938-0205

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

*List any special equipment or utensils needed:

*Indicate any other comments about the child's eating or feeding patterns:

*Physician's Name and Office Phone Number		*Office Stamp
***Physician/Medical Authority's Signature**		*Date
***Part 4: Parent Signature**		*Date
***Part 5: Child Care Facility Signature**		*Date

LITTLE SCHOLARS ACADEMY 5000005539 (215) 342-9500

Signing this section is optional, but may prevent delays by allowing us to speak with the physician.

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____(medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____(center/facility) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date).

This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has legal authority to sign on behalf of that person.

***Parent/Guardian Signature**:_____ *Date:_____

MEDICAL FORM Page 2 of 2

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

*Parent confirmed no change in diet order: Date:_____ Initial:_____ | Date:_____ Initial:_____

Date:_____ Initial:_____ | Date:_____ Initial:_____