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 I understand that permission to release this information may be rescinded at any time except when the information has already been released.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:_____