CENTRAL BUCKS SCHOOL DISTRICT
EDUCATION FOUNDATION

Thank you for taking the time to apply to the **Learning Without Limits** Tutoring Grant. Please follow the instructions below when completing the Release of Information form (next page).

If any of the instructions are not followed, we will not be able to process your application which may delay and thus impact your ability to receive a grant for tutoring.

INSTRUCTIONS

1. The line titled “Re” please put the student’s name.
2. For the line “DOB” please put the student’s Date of Birth
3. The first line in the following paragraph *must* be the adult/legal guardian’s full (first and last) legal name.
4. The second line must be “Central Bucks School District Education Foundation”
5. The third line *must* be the student’s full (first and last) legal name.
6. Please check boxes “Special Education Records” **and** “school records”
7. The line that says, “for the purpose of” please enter “Tutoring Grant Application”
8. For the line that discuses expiration, please enter the date that you are filling out the application. Your consent will expire one year from the date on the line.
9. Please complete the signatures.

Once completed, please return to the Learning Without Limits website page and upload the completed form.

ANY APPLICATIONS SUBMITTED WITHOUT THE COMPLETED FORM ARE NOT ELIGIBLE.

If you have any questions or concerns, please contact the Executive Director, Jackie, at Jackie@CbEducationFoundation.org

CENTRAL BUCKS
SCHOOL DISTRICT

LEADING THE WAY

The Central Bucks Schools will provide all students with the academic and problem-solving skills essential for personaldevelopment, responsible citizenship, and life-long learning.

Re:_____

DOB:_____

I,_____herby authorize the Central Bucks School District to obtain from/release to and communicate with Central Bucks School District Education Foundation regarding information related to_____, including those items specifically checked below:

- ☐ psychological evaluation
- ☐ health records
- ☐ psychiatric evaluation
- ☐ social work reports
- ☐ neurological evaluation
- ☑ special education records
- ☐ medical history
- ☐ treatment/aftercare plan
- ☐ discharge summary
- ☑ school records: academic records, standardized test data, anecdotal information
- ☐ other: _____

for the purpose of: Tutoring Grant Application

This consent will begin on the date of this authorization and will expire one year later on _____unless revoked in the interim. I, understand herby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release. All information released will be handled confidentially in compliance with the Federal Privacy Act (PL 93-380 Sec. 438), the Pennsylvania Mental Health Procedures Act , and the Federal Educational Rights Privacy Act or FERPA (www.ed.gov/policy/gen/guid/fpco/ferpa/index.html).

_____ _____

Signature of Witness *date* *Signature parent/guardian*

Copy given to_____ _____

Signature of student (if age 14 or above)

_____

Date of authorization

THIS INFORMATION IS FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS PROHIBIT MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS (42 CFR Part 2). A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INOFRMATION IS NOT SUFFICIENT.