Kid Logistics - *Kid Busy Living!* Program

Cystic Fibrosis Care Provider Authorization

Please fill out the top portion of this page yourself, then have your child's Cystic Fibrosis care provider fill out the rest of this page. This page **MUST** be completed and included with your application to be considered for approval.

Applicant's Name:______________________________ Applicant's DOB:__________________

Applicant's chosen activity:____

CF Care Provider Information

Physician's Name:____

Name of CF Clinic:____

Clinic Mailing Address:____

City: ____________________________ State:____________ Zip:__________________________

Contact Person:___________________________ Position:_____________________________

Phone: ________________________ E-mail:_______________________________________

To Be Completed by CF Care Provider

1. Do you verify that the applicant has been diagnosed with Cystic Fibrosis? **Yes/No**
2. Do you endorse the applicant's participation in the activity listed above as potentially beneficial to their physical and/or mental health? **Yes/No**
3. Do you have any concerns about their participation in these activities? If so, please describe:

   ____

As the primary CF care provider for the patient listed above, I support and encourage their participation in the activity listed in this application.

________________________	______________________________	______________
CF Physician (Signature)	CF Physician (Print Name)	Date

Return this form to: Kid Logistics, PO Box 320702, Flowood, MS 39232 or kiri@kidlogistics.com