SALUS UNIVERSITY
Speech-Language Institute

T 215.780.3150
F 215.780.3169

8380 Old York Road, Suite 2100
Elkins Park, PA 19027-1539

CONSENT TO USE FOOD IN TREATMENT SESSIONS

I give my permission for Department of Speech-Language Pathology at Salus University to use food in my/my child's therapy sessions. If food is to be used, I understand that it will be explained to me in what manner, and how the use of food may benefit the success of therapy.

_____ I have/my child has no known food allergies or intolerance.

_____ I am/my child is allergic to certain foods. Please do not use these foods in therapy sessions.

Allergy/Reaction/Treatment:

____
Client's Name

____
Signature of Client Date

____
Signature of Parent/Caregiver Date