REGINA ROMAN CATHOLIC SCHOOL DIVISION NO. 81

PARENT AUTHORIZATION FOR HEALTH CARE INTERVENTION

Health-related services and/or the dispensing of medication will be authorized by the school division only if the medication and/or procedures cannot be done before or after school hours. A new form is required at the beginning of each new school year.

IF THERE IS A CHANGE IN DOSAGE OR NEW PRESCRIPTION, A NEW FORM MUST BE SUBMITTED.

Student Name _____ **School** _____
(Last) (First)

Birth Date _____ **Grade** _____
(Day) (Month) (Year)

Teacher _____

Parent(s)/Guardian(s) _____ **S.H.S.P. #** _____

Home Address: _____ **In case of emergency, contact:**

Mother Phone: _____ _____ **Phone:** _____
(Home) (Business) (Name)

Father Phone: _____ _____ **Phone:** _____
(Home) (Business) (Name)

REQUEST FOR AUTHORIZATION

I hereby request and authorize the administration of the following prescribed and non-prescribed medication and treatments/procedures for my child, _____ by non-medically trained staff at _____ School.

_____ _____
(Signature of Parent/Guardian) (Date)

Name of Student's Doctor _____ Phone: _____

Name of Student's Pharmacy _____ Phone: _____

MEDICATION	DOSAGE	TIMES FOR ADMINISTRATION	SIDE EFFECTS
1.			
2.			
3.			

MEDICAL TREATMENTS AND/OR PROCEDURES

1.	2.

ALLERGIES AND/OR CONCERNS

1.	3.
2.	4.

THIS FORM MUST BE COMPLETED PRIOR TO NON-EMERGENCY INTERVENTIONS.

Parent's/guardian's signature indicates permission for school division personnel to contact the student's physician if it is deemed necessary.

_____ _____
(Signature of Parent/Guardian) (Date)

A copy should be provided to the following: Principal's copy (kept in pupil's "cum file"); Designated Administrator of Medication; Home Room/Classroom Teacher & Parents.