

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)

Parent(s)/Guardian(s) _____ Teacher _____

Home Address: _____ S.H.S.P. # _____

Mother Phone: _____ In case of emergency, contact: _____
(Home) (Business) (Name) Phone: _____

Father Phone: _____ (Name) 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.
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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.