Form 316.1

Lloydminster Catholic School Division

PARENT AUTHORIZATION FOR CHRONIC

HEALTH CARE AT SCHOOL

We (I), the undersigned, who are the parents/guardians of

(Name) (Birth date)

request that the following health-care service(s)

be administrated to our child. We understand that a designated person(s) will be performing the above-mentioned health-care service. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure that has been approved by our physician.

(Name) (Address) (Phone number)

We will notify the school immediately if the health status of _____ changes, we change physicians, or there is a change or cancellation of the procedure.

We understand that the above-mentioned procedure should be scheduled before or after school hours whenever possible.

We are aware our child's photo will be displayed with Form 316-6 in an area easily accessible by school personnel and have confirmed this on the FIOP form (see registration.)

Signature of parents/guardians: _____

_____

Address: _____

Telephone Numbers: _____ _____

(Home) (Work)

_____ _____

(Home) (Work)

Date: _____