Lloydminster Catholic School Division
LETTER TO DOCTOR REGARDING HEALTH SERVICES

Dear Doctor: _____

Re: Name _____ Birth Date _____

Address _____

School and Grade _____

We have been informed that the above-mentioned child, a patient of yours, is required to take health care during school hours.

Since this procedure involves additional responsibilities on behalf of school personnel, we ask for your cooperation in reviewing the need for special services and/or medication during school hours for this child, and if you decide it is essential, please record the name of the drug, the dose, and any necessary health services instruction. Please include specific information on a required service and the training needed. Your signature authorizing this service(s) by school personnel is essential.

We have attached relevant LCSD supports:

- ❑ school procedure in place and/or
- ❑ LCSD Occupational Therapist Assessment and/or recommendations.

Principal
Authorization for release of information: Parent Signature: _____

Medical Authorization (To be completed by the doctor)

Type of Services Required: _____

Frequency of Service: _____ Time(s) to be administered: _____

Anticipated duration of services or medical intervention:

- ❑ Ongoing until further notice by a doctor
- ❑ For the period _____to _____

Health Care Directive – Description: (Please indicate a health care professional by name and contact information that would be authorized to provide training to the staff.)

_____

_____

Name of Doctor:_____ Date: _____
Signature of Doctor: _____