Form 319-1

Lloydminster Catholic School Division

PARENT AUTHORIZATION FOR TEMPORARY HEALTH CARE AT SCHOOL

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

____

(Name)

request that the following health-care service(s)

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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.

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(Name) (Phone number)

We will notify the school immediately if the health status of our child 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.

Signature of parents/guardians: ____

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Date: ______________________________