

# Form 316.1 Parent Authorization for Chronic Health Care At School

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## Lloydminster Catholic School Division PARENT AUTHORIZATION FOR CHRONIC HEALTH CARE AT SCHOOL

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

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(Name)

(Birth date)

request that the following health-care service(s)

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be administered 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)

(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: \_\_\_\_\_