

---

**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)

---

---

---

---

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)

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

Date: \_\_\_\_\_