Medical Treatment: Information and Consent Form

Student: ______________________________ Date of Birth: ______________________________

School: __________________________________

1. Physician: The medical procedures prescribed herein for ____________ (Name) will be necessary for the following duration: Commencing on ____________ (Date), concluding on ____________ (Date)

*This information may remain on file if there are no changes to this student's medical condition.

To be completed by Physician:

In order to accommodate the pupil named above, the following information is required:

i) Nature of Medical Condition: ______________________________

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ii) Description of Medical Treatment Required at School ______________________________

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iii) Facilities / Materials Required: ______________________________

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iv) Specifics of Required Staff Participation: ______________________________

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To be completed by Physician:

v) Is the individual responsible for the provision of medical treatment required to be registered under the Regulated Health Professions Act? YES ______ NO _____

vi) Possible Treatment Side Effects / Action Necessary: ____

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vii) Other: ____

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Telephone

____________________________ ____________________________

Physician's Signature Date

2. Parent / Guardian: Based on the information provided above, I request and authorize school participation in the provision of medical treatment.

____________________ ____________________ ____________________

Home Telephone Alternate Telephone Emergency Telephone

____________________ ____________________________

Date Parent / Guardian Signature

3. **Principal:** The school's participation in the provision of medical treatment as noted above shall be as follows:

(i) Actions: ____

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(ii) Participants: ____

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______________________________ ______________________________
Date Principal's Signature