



Northeastern Catholic District School Board

Authorization for the Provision of Health Support Services	
Name of Student	
Date of Birth	
Name of Parent	
Address	
Telephone Contact	Home: Work: Mobile:
Name of School	
Name of Teacher	

Identification of Health Support Services Required			
Please check (✓) all that apply.			
(✓)	Service	(✓)	Service
	Physical / Occupational Therapy <input type="checkbox"/> General Maintenance Exercise <input type="checkbox"/> Speech Pathology <input type="checkbox"/> Speech Correction/Remediation		Catheterization <input type="checkbox"/> Manual <input type="checkbox"/> Postural Drainage/Suctioning <input type="checkbox"/> Tube Feeding
	Lifting and Positioning <input type="checkbox"/> Assistance with Mobility		Injection of Medication
	All services in Children's Residential Care Treatment Facilities		
Health Support Service Information			
Name of Agency			
Name of Health Care Provider			
Date of Initial Service			
Dates for Which Authorization Applies			

We hereby request that the above checked Health Support Service(s) be provided for our child and authorize the Northeastern Catholic District School Board to release any pertinent information which may be required by the appropriate agency.

Parent Signature: _____

Date: _____

The legal authorization for the collection of this information is the Education Act. The NCDSB uses the information for the purpose of carrying out its responsibilities under the Act. If you require clarification about the collection of information, contact the PIM Coordinator at 705.268.7443.

