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 ☐ General Maintenance Exercise ☐ Speech Pathology ☐ Speech Correction/Remediation		Catheterization ☐ Manual ☐ Postural Drainage/Suctioning ☐ Tube Feeding
	Lifting and Positioning ☐ 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.

383 Birch Street North, Timmins ON P4N 6E8
[T] 705-268-7443 [F] 705-267-3590 [W] www.ncdsb.on.ca

Northeastern Catholic District School Board

Authorization for the Administration of Medication	
Name of Student	
Date of Birth	
Name of Parent	
Address	
Telephone Contact	Home: Work: Mobile:
Name of School	
Name of Teacher	

NOTE TO PHYSICIAN: Please indicate why medication must be administered at school.

Name of Medication	
Storage and Safe Keeping Requirements	
Dosage	
Frequency	
Method of Administration	
Dates for which authorization applies	
Possible Side Effects	
Additional Information	
Name of Physician	
Physician's Contact Information	
Physician's Signature	

Parent Authorization

We hereby request that the above medication and procedures as outlined by our Physician be administered to our child. We understand that the Northeastern Catholic District School Board or its employees will not be legally responsible for the administration of oral medication.

Parent Signature: ______________________________ **Date:** ____________________

Authorization must be completed at the beginning of each school year and/or every time that a prescription is modified and the oral administration of medications is required during school hours.

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Northeastern Catholic District School Board

Student Record Form for the Administration of Medication	
Name of School	
Name of Student	
Name of Parent	
Parent Contact Information	Home: Work: Mobile:
Name of Medication	
Name of Physician	
Physician Contact Information	

Names of persons responsible for the administration of medication	**School Principal:** **Teacher(s) in Charge:**
Method of Administration and/or Special Instructions	

Dosage	Date	Time	Notes	Signature/Initial

Principal Signature: ______________________ **Date:** ______________

Northeastern Catholic District School Board

Student Record Form for the Administration of Medication				
Name of Student				
Dosage	**Date**	**Time**	**Notes**	**Signature/Initial**

Principal Signature: ______________________________ **Date:** ____________________

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