Medical Treatment: Information and Consent Form

Pupil:_____ D.O.B. _____

School:_____ Placement_____

Note: This form is completed in respect of in-school participation in the provision of medical treatment.

The medical procedures prescribed herein for _____, will be necessary for the following duration
Name

Commencing on _____, concluding on _____.
Date Date

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

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

(i) Nature of Medical Condition: _____

_____

_____

(ii) Description of Medical Treatment Required at School: _____

_____

_____

_____

(iii) Facilities / Materials Required: _____

_____

_____

_____

(iv) Specifics of Required Staff Participation:

_____

_____

_____

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

(vi) Possible Treatment Side Effects / Action Necessary: _____

_____

_____

_____

(vii) Other: _____

_____

_____

_____

Telephone

_____ _____

Date

Physician's Signature

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 schools participation in the provision of medical treatment as noted above shall be as follows:

(i) Activities: _____

_____

_____

(ii) Participants: _____

_____

_____

_____ _____

Date

Principal's Signature