

**REGINA ROMAN CATHOLIC SCHOOL DIVISION NO. 81**  
**PARENT AUTHORIZATION FOR HEALTH CARE INTERVENTION**

*Health-related services and/or the dispensing of medication will be authorized by the school division only if the medication and/or procedures cannot be done before or after school hours. A new form is required at the beginning of each new school year.*

**IF THERE IS A CHANGE IN DOSAGE OR NEW PRESCRIPTION, A NEW FORM MUST BE SUBMITTED.**

Student Name _____	School _____	
(Last) _____	(First) _____	
Birth Date _____	Grade _____	
(Day) _____	(Month) _____	(Year) _____
Parent(s)/Guardian(s) _____	Teacher _____	
Home Address: _____	S.H.S.P. # _____	
Mother Phone: _____	In case of emergency, contact: _____	
(Home) _____	Phone: _____	
Father Phone: _____	(Name) _____	
(Home) _____	Phone: _____	
(Business) _____	(Name) _____	

**REQUEST FOR AUTHORIZATION**

I hereby request and authorize the administration of the following prescribed and non-prescribed medication and treatments/procedures for my child, \_\_\_\_\_ by non-medically trained staff at \_\_\_\_\_ School.

\_\_\_\_\_  
 (Signature of Parent/Guardian)

\_\_\_\_\_  
 (Date)

Name of Student's Doctor \_\_\_\_\_

Phone: \_\_\_\_\_

Name of Student's Pharmacy \_\_\_\_\_

Phone: \_\_\_\_\_

MEDICATION	DOSAGE	TIMES FOR ADMINISTRATION	SIDE EFFECTS
1.			
2.			
3.			

**MEDICAL TREATMENTS AND/OR PROCEDURES**

1.	2.
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**ALLERGIES AND/OR CONCERNs**

1.	3.
2.	4.

**THIS FORM MUST BE COMPLETED PRIOR TO NON-EMERGENCY INTERVENTIONS.**

*Parent's/guardian's signature indicates permission for school division personnel to contact the student's physician if it is deemed necessary.*

\_\_\_\_\_  
 (Signature of Parent/Guardian)

\_\_\_\_\_  
 (Date)

**A copy should be provided to the following: Principal's copy (kept in pupil's "cum file"); Designated Administrator of Medication; Home Room/Classroom Teacher & Parents.**