

**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) (Business) (Name) Phone: \_\_\_\_\_

Father Phone: \_\_\_\_\_ (Name) Phone: \_\_\_\_\_  
(Home) (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.**