REQUEST TO ADMINISTER MEDICATION OR MEDICAL CARE

The personal information on this form is collected under the terms of section 33 c) of the Freedom of Information and Protection of Privacy Act (FOIPP). This information will be used only for the administration of medical care as described below. If you have any questions concerning the collection or use of this information, please contact the Treasurer of the Conseil scolaire du Nord Ouest at 780-624-8855.

INFORMATION

Student Name: _____ Date of Birth: _____

Health Insurance Number: _____

Designated medical establishment/hospital and/or
name and phone number of physician: _____

PARENT/GUARDIAN CONTACT INFORMATION

Name of legal parent(s)/tutor(s) : _____

Legal address: _____

Telephone : Home _____

Cell (mother) _____ Work (mother) _____

Cell (father) _____ Work (father) _____

ALTERNATE CONTACT (IN CASE OF EMERGENCY)

Name: _____ Telephone : _____

Legal address: _____

PARENTAL REQUEST

I, _____ , authorize the personnel of _____

Name of parent/guardian Name of school

to administer medicine or medical care to: _____

Name of Student

Name of medication	Dose	Frequency

☐ A copy of pharmaceutical information (including a description of side effects) has been provided to the school.

Name of medication	Dose	Frequency

❑ A copy of pharmaceutical information (including a description of side effects) has been provided to the school.

Date **Signature of Parent/Guardian**