

Medical Treatment: Information and Consent Form

Pupil: _____ D.O.B. _____

School: **Lakeshore School** Grade: _____

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

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: _____

Date Physician's Signature Telephone

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's Signature

3. Principal: The school's participation in the provision of medical treatment as noted above shall be as follows:

(i) Activities: _____

(ii) Participants: _____

Date Principal's Signature