

## Northeastern Catholic District School Board

### Authorization for the Provision of Health Support Services

Name of Student: \_\_\_\_\_ Date: \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Name of School: \_\_\_\_\_  
Name of Teacher: \_\_\_\_\_

#### Name of Health Support Services Required: (check)

- |   |   |
|---|---|
| <input type="checkbox"/> Injection of Medication      | <input type="checkbox"/> Physio/Occupational:   |
| <input type="checkbox"/> Catheterization              | <input type="checkbox"/> Intensive Clinical   |
| <input type="checkbox"/> Manual                       | <input type="checkbox"/> General Maintenance Exercises                                    |
| <input type="checkbox"/> Postural Drainage/Suctioning | <input type="checkbox"/> Speech Pathology   |
| <input type="checkbox"/> Tube Feeding                 | <input type="checkbox"/> Speech Correction and Remediation                                |
| <input type="checkbox"/> Lifting and Positioning      | <input type="checkbox"/> All Services in Children's Residential Care Treatment Facilities |
| <input type="checkbox"/> Assistance with Mobility     |   |

We hereby request that the above checked Health Support Service(s) be provided for our child and authorize the Northeastern Catholic District School Board to release any pertinent information which may be required by the Community Care Access Programme or appropriate agency. We agree to meet with the Principal to discuss the request indicated above and to ask:

Dr. \_\_\_\_\_ for a referral to the Community Care Access Programme or appropriate agency.

\_\_\_\_\_  
(Parent/Guardian's Signature)

\_\_\_\_\_  
(Parent/Guardian's Telephone Number)

#### For School Use Only

Name of Health Care Provider Contact: \_\_\_\_\_ Date of Contact: \_\_\_\_\_  
Medical Referral Completed: ☐ yes ☐ no Date of Initial Service: \_\_\_\_\_  
Type of Service: \_\_\_\_\_  
Agency Administering Service: \_\_\_\_\_  
School Involvement: \_\_\_\_\_  
Dates for Which Authorization Applies: \_\_\_\_\_  
Other Comments: \_\_\_\_\_

**NOTE:** The legal authorization for the collection of this information is the Education Act. The Board uses the information for the purpose of carrying out its responsibilities under the Act. If you require clarification about the collection of information, contact the Freedom of Information Coordinator at (705) 268-7443.