Peterborough Victoria
Northumberland and Clarington
Catholic District School Board

AUTHORIZATION FOR ADMINISTRATION OF SPECIAL SERVICES

Student Name: _____ Date of Birth: _____

Home Address: _____

City: _____ Postal Code: _____ Home Phone: _____

School: _____ Teacher: _____

SPECIAL SERVICES INFORMATION

1. Name of Service Required: _____
2. When is Service Administered: _____
3. Type of Training Required: _____
4. Possible Adverse Reactions: _____
5. Physician's Name: _____

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

Please bring any written documentation which would be helpful.

DESIGNATED PERSON PROVIDING SPECIAL EDUCATION SERVICES

I agree to provide the Special Services as described above.

Signature of Person Providing Special Services: _____ Date: _____

Principal's Signature: _____ Date: _____

PARENT'S/GUARDIAN'S APPROVAL

I hereby request and give permission to the School Principal to make arrangements for administration of special services as specified herein to my child named above. It is understood that school staff will administer special services on my behalf and not as health professionals. Any changes to the above procedures shall be immediately reported by the Parent/Guardian to the School Principal or designate.

Parent's/Guardian's Signature: _____ Date: _____

NOTE

A new Authorization Form must be submitted each school year and whenever special services are modified.

Information Collection Authorization: This information is collected pursuant to the Board's education responsibilities as set out in the Education Act and is within guidelines set out in the Municipal Freedom of Information and Protection of Privacy Act, 1989. The information is collected for education purposes and will be used to meet student medical needs. This information will become part of the Ontario Student Record. Any questions with respect to this information should be directed to the School Principal. Users: Staff administering medication or special services.