Northeastern Catholic District School Board

Authorization for the Provision of Health Support Services	
Name of Student	
Date of Birth	
Name of Parent	
Address	
Telephone Contact	Home: Work: Mobile:
Name of School	
Name of Teacher	

Identification of Health Support Services Required Please check (✓) all that apply.			
(✓)	**Service**	(✓)	**Service**
	Physical / Occupational Therapy ☐ General Maintenance Exercise ☐ Speech Pathology ☐ Speech Correction/Remediation		Catheterization ☐ Manual ☐ Postural Drainage/Suctioning ☐ Tube Feeding
	Lifting and Positioning ☐ Assistance with Mobility		Injection of Medication
	All services in Children's Residential Care Treatment Facilities		

Health Support Service Information	
Name of Agency	
Name of Health Care Provider	
Date of Initial Service	
Dates for Which Authorization Applies	

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 appropriate agency.

Parent Signature: _____ **Date:** _____

The legal authorization for the collection of this information is the *Education Act*. The NCDSB 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 PIM Coordinator at 705.268.7443.

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