Huron-Superior Catholic
DISTRICT SCHOOL BOARD

Authorization for the Performance of School Health Services

Student:		**D.O.B.:**
Address:		**Telephone:**
School:	**Grade:**	**Teacher:**

PART 1 – PARENT/GUARDIAN'S CONSENT

I hereby request and give permission for the performance of a School Health Services procedure (e.g., Clean Intermittent Catheterization, g-tube feeding, shallow suctioning) by a trained Educational Assistant to my child at the above school for the lesser of this school year duration, all as set forth by the Home and Community Care Support Services.

I hereby release and hold harmless the Huron-Superior Catholic District School Board and its employees from any liability arising as a consequence of the performance of this procedure.

I understand that I may be required to perform this procedure in special circumstances.

_____   _____

Parent/Guardian's Signature   **Date**

PART II – HOME AND COMMUNITY CARE SUPPORT SERVICES STATEMENT

Refer to the attached order from the health care provider to certify that:

☐ The above-named student has a chronic medical condition which makes him/her unable to attend school safely unless he/she receives the following procedure:

Specialized Procedure Required:
Frequency of Procedure:
Additional Information (i.e., Possible Complications):

☐ The performance of this procedure during school hours is necessary for this child's attendance at school and is safe to be carried out by trained staff.

☐ Health care provider order is attached.

PART III – ACKNOWLEDGMENT OF TRAINING

The following Educational Assistants have been trained by Home Community Support Services staff in performing this procedure.

Name:	Date of Training:
Name:	Date of Training:

I hereby certify that the above-named Educational Assistants are trained in performing the specified School Health Services procedure.

Trainer's Name: _____   **Position: _____**

_____   _____

Trainer's Signature   **Date**

NOTE: Authorization Form must be submitted each school year and whenever the procedure is modified.

Copies to: Parent, Physician/Home & Community Care Support Services, Principal, OSR