FORM 'F'

PARENTAL CONSENT AND AUTHORIZATION FOR MEDICAL TREATMENT
(For Students under 18 years of age)

Child's Information

_____ _____
Child's name Date of Birth

_____ _____
Address (Civic and Street Name) Home phone number

_____
City and Postal Code

_____ _____
Parental Contact Phone number (work and/or cell)

Supervising Teacher Information

_____ _____
Supervising Teacher's name Supervising Teacher's name

Parental Authorization

In the event that I, the parent/guardian of the above-named child, am not available* to provide or refuse consent, I hereby authorize one or both of the above-named Supervising Teachers to provide consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic tests, etc.) for the above-named child which, in the opinion of a licensed medical practitioner, are necessary to protect the physical health of the above-named child. This authorization shall be effective from _____ until _____.

*In accordance with the definition provided in the *Health Care Consent Act, 1996 (*the *"Act")*, a person is "available" if it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a consent or refusal.

Note: Pursuant to the *Act*, consents are not required if there is an emergency and the delay required to obtain a consent or refusal on the child's behalf will prolong the suffering that the child is apparently experiencing or will put the child at risk of sustaining serious bodily harm. Medical practitioners in other jurisdictions are likely subject to similar provisions.

_____

Parent/Guardian (circle one) Date

_____

Parent/Guardian (circle one) Date

_____

Witness - Print name: Date