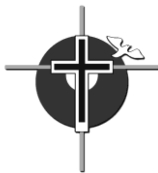

FORM ‘G’

CONSENT AND AUTHORIZATION FOR MEDICAL TREATMENT

(For Students 18 years of age and over)

Student’s Information

____________________	____________
Student’s name	Date of Birth
Address (Civic and Street Name)	Home phone number
City and Postal Code	
Parent/Guardian	Phone number (work and/or cell)

Supervising Teacher Information

____________________	____________________
Supervising Teacher’s name	Supervising Teacher’s name

Consent and Authorization

In the event that I, the above-named student, am unable to provide or refuse consent, I hereby authorize my above-named parent/guardian 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 me which, in the opinion of a licensed medical practitioner, are necessary to protect my physical health. In the event that my said parent is not available* to provide such consent, then, in that event, I authorize one or both of the above-named Supervising Teachers to provide such consent in the place of my parent. 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 student’s behalf will prolong the suffering that the student is apparently experiencing or will put the student at risk of sustaining serious bodily harm. Medical practitioners in other jurisdictions are likely subject to similar provisions.

____

Student Date

____

Parent/Guardian (circle one) Date

____

Witness - Print name: Date