Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

MOCLI60724

Dossier : _____

Nom, prénom : _____

Date de naissance : _____ ☐ F ☐ M
aaaa/mm/jj

NAM : _____ Exp. _____
aaaa/mm

Nom, prénom de la mère : _____

Installation : _____

AUTHORIZATION TO SHARE INFORMATION IN A SCHOOL SETTING

This authorization enables the sharing of required information with key partners of the DPJASP school nursing staff.

In my capacity as:
☐ User (14 years and older)
☐ Authorized person: _____
☐ FATHER ☐ MOTHER ☐ TUTOR

	Yes	No
• I authorize the school nursing team to contact my community pharmacy and to access my Québec Health Record to obtain information about my medications.	☐	☐
• I authorize the school nursing team to share my health information with teams at the following institutions: ☐School: _____ (staff members involved in my care) ☐Daycare (specify): _____ ☐Other: _____ ☐Other: _____	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
• I understand that I may withdraw my authorization, in whole or in part, at any time.	☐	☐

This authorization is valid for the current school year, starting from the date of signature of this document.

Signature of user/authorized person:_____ **Date:** _____
yyyy/mm/dd

Signature and title of professional: _____ **Date:** _____
yyyy/mm/dd