THE DISTRICT OF THUNDER BAY SOCIAL SERVICES ADMINISTRATION BOARD

Thunder Bay
Fax: 807.345.7921

Geraldton, Longlac,
Manitouwadge Marathon, Nakina,
Nipigon, Schreiber, Terrace Bay
Fax: 807-824-1372

MEDICAL INFORMATION

TO: _____
(Physician's Name)

I, _____, in accordance with *Section 31 (a) and 31 (b)*
(Recipient's Name)
of the *Municipal Freedom of Information and Protection of Privacy Act,* hereby authorize and direct you to release to The District of Thunder Bay Social Services Administration Board, Children's Services, the information requested below.

DATED at _____, this _____day of _____, 20__.

_____
(Recipient's Signature)

PATIENT'S NAME: _____

ADDRESS: _____
Postal Code

PHONE: _____

1. Is this person a regular patient of yours? Yes No (circle one)

2. I strongly recommend the child(ren) attend child care due to parent's medical needs. Yes No (circle one)
   If yes, please complete the type of child care needed: (check one)
   Full Days (6+ hours)/Full-time (5 days/week) _____
   Part Days (< 6 hours)/Full-time (5 days/week) _____
   Part Days (< 6 hours)/Part-time (< 5 days/week) _____

3. Do you expect sufficient improvement to take place in the health of this patient to allow him/her to care for his/her child(ren): Yes No (circle one)

   If yes, when? _____ (date) Full-time ___ Part-time ___check one)

Signature of Attending Physician: _____

Name of Physician: _____

Address: _____ Date:_____