HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

ADULT STUDENT/PARENT/GUARDIAN REQUEST AND CONSENT FOR EPILEPSY INTERVENTIONS

Student's Name: _____ O.E.N: _____

Birthdate: _____ School: _____
(Year/Month/Day)

Address: _____
(Street) (City) (Postal Code)

Please fill out if you are the parent or guardian:

I/We _____/_____,

the parents/guardians of _____ understand that:
(Name of Student)

- the principal, teachers and other school staff are not health care professionals and have no more information about the medical condition of my/our child than that which has been provided to them in writing by myself/ourselves or by my/our child's doctor. They are not experts in recognizing the symptoms of my/our child's medical condition or in treating it;

- to the extent possible, my/our child has been trained by me/us and by health care professionals, to recognize her/his own need for intervention/medication and to respond to the need by requesting intervention or by self-administering the appropriate medication; **and,**

- where feasible, my/our child is responsible for the necessary medication to address the epileptic condition.

Please fill out if you are an Adult Student:

I _____understand that:

- the principal, teachers and other school staff are not health care professionals and have no more information about my medical condition than what has been provided to them in writing by myself or by my doctor. They are not experts in recognizing the symptoms of my medical condition or in treating it;

- to the extent possible, I have been trained by my health care professional, to recognize my own need for intervention/medication and to respond to the need by requesting intervention or by self-administering the appropriate medication; **and,**

- where feasible, I am responsible for the necessary medication to address the epileptic condition.

- I/we are responsible for ensuring that –
    - all medical updates/changes or emergency information will be provided for the school staff immediately;
    - the teacher will be instructed concerning the incidents relating to seizures about which I/we wish to be informed.

- The specific incidents related to seizures about which I/we would like to be informed are:

- _____
- _____
- _____
- _____
- _____

In the event of an emergency (a seizure lasting more than 5 minutes), I/we authorize the school staff to obtain emergency services and to authorize such emergency treatments as are necessary. I/We agree to assume responsibility for all costs associated with the medical intervention.

I/We give permission to the school staff to post the Individual Epilepsy Action Plan, with a picture of myself and/or of my/our child, in appropriate locations within the school.

I/We have reviewed and agree to the Epilepsy Management Plan for myself and/or my/our child.

Adult Student Name: _____

Adult Student Signature: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____
(Year) (Month) (Day)