



## HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

<p style="text-align: center;">ADULT STUDENT/PARENT/GUARDIAN REQUEST AND CONSENT FOR EPILEPSY INTERVENTIONS</p>
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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;
- 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 professionals, to recognize my own need for intervention/medication and to respond to the need by requesting intervention or by self-administering the appropriate medication;
- 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/Parent/Guardian Name: \_\_\_\_\_

Adult Student/Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
(Year) (Month) (Day)

HAMILTON WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION- PHYSICIAN/NURSE PRACTITIONER FORM**

**Part I To be completed by the attending physician when medication is initiated or changed.**

(Please type or print)

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ School: \_\_\_\_\_

This is to advise that I have prescribed the administration of the following medication listed below for those days when the above-mentioned student is in school:

1. Name of Medication \_\_\_\_\_

Method of Administration \_\_\_\_\_

Dosage \_\_\_\_\_ Time(s) \_\_\_\_\_

2. Expected date of discontinuation: \_\_\_\_\_

3. Must the medication be taken during school hours? \_\_\_\_\_

4. Contra-indications to giving medication: \_\_\_\_\_

5. Please specify possible hazards or side effects of medication:

\_\_\_\_\_

\_\_\_\_\_

6. Action to be taken should a reaction occur: \_\_\_\_\_

\_\_\_\_\_

7. Allergies which should be noted (if applicable): \_\_\_\_\_

\_\_\_\_\_

8. Additional instructions (e.g., storage of medication, etc.):

Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION - ADULT STUDENT/PARENT/GUARDIAN FORM

PART II -To be completed by Adult Student/Parent/Guardian when medication is initiated, changed, and annually at the beginning of each new school year.

This is to authorize the administration of the medication(s) prescribed by the attending physician/nurse practitioner from \_\_\_\_\_ to \_\_\_\_\_ for:

Student's Name: \_\_\_\_\_ Birthdate: (yyyy/mm/dd) \_\_\_\_\_

School: \_\_\_\_\_

MedicAlert I. D.: Yes \_\_\_\_\_ No \_\_\_\_\_

- I give permission for my child to self-administer the medication prescribed by the attending physician. Yes \_\_\_ No \_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ (Year, Month, Day)

- I release and agree to indemnify the Hamilton-Wentworth Catholic District School Board and its staff from any liability or damages incurred by any party as a consequence of the administration or lack of administration of medication to myself or my child.

Signature of Parent/Guardian/Adult Student: \_\_\_\_\_

Date: \_\_\_\_\_ (Year, Month, Day)

NOTE:

- Parents/guardians/adult students are requested to PLACE MEDICATION IN INDIVIDUAL CONTAINERS, preferably those in which the medication was supplied from the pharmacist/physician.
The containers should be PROPERLY LABELLED indicating the NAME of MEDICATION, STUDENT'S NAME, AND ADMINISTRATION DIRECTIONS.
The medication will be delivered by parent/guardian/adult student, according to an agreed schedule, to the Principal or designated person for safe keeping, unless otherwise determined.

In case of EMERGENCY, the contact persons are:

Name \_\_\_\_\_ Name \_\_\_\_\_

Telephone \_\_\_\_\_ Telephone \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

Under The Municipal Freedom of Information and Protection of Privacy Act, 1989, information in forms and documents pertaining to a student registered/enrolled within The Hamilton-Wentworth Catholic District School Board is collected under the legal authority of The Education Act, and its Regulations, and the Ontario Student Record (O.S.R.) Guideline, 1989. This information is being collected to ensure that the educational program which is provided meets your child's needs.



**INDIVIDUAL EPILEPSY PLAN OF CARE**

**STUDENT INFORMATION**

Student Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Ontario Ed. # \_\_\_\_\_ Age \_\_\_\_\_ **Student Colour Photo**

Grade \_\_\_\_\_ Teacher(s) \_\_\_\_\_

**EMERGENCY CONTACTS (LIST IN PRIORITY)**

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

Has an emergency rescue medication been prescribed?  Yes  No

If yes, attach the rescue medication plan, healthcare providers' orders and authorization from the student's parent(s)/guardian(s) for a trained person to administer the medication.

Note: Rescue medication training for the prescribed rescue medication and route of administration (e.g. buccal or intranasal) must be done in collaboration with a regulated healthcare professional.

**KNOWN SEIZURE TRIGGERS**

CHECK (✓) ALL THOSE THAT APPLY

- Stress
- Menstrual Cycle
- Inactivity
- Changes In Diet
- Lack Of Sleep
- Electronic Stimulation (TV, Videos, Florescent Lights)
- Illness
- Improper Medication Balance
- Change In Weather
- Other \_\_\_\_\_
- Any Other Medical Condition or Allergy? \_\_\_\_\_

## DAILY/ROUTINE EPILEPSY MANAGEMENT

### DESCRIPTION OF SEIZURE (NON-CONVULSIVE)

### ACTION:

(e.g. description of dietary therapy, risks to be mitigated, trigger avoidance.)

### DESCRIPTION OF SEIZURE (CONVULSIVE)

### ACTION:

## SEIZURE MANAGEMENT

Note: It is possible for a student to have more than one seizure type.  
Record information for each seizure type.

### SEIZURE TYPE

### ACTIONS TO TAKE DURING SEIZURE

(e.g. tonic-clonic, absence, simple partial, complex partial, atonic, myoclonic, infantile spasms)

Type: \_\_\_\_\_

Description: \_\_\_\_\_

Frequency of seizure activity: \_\_\_\_\_

Typical seizure duration: \_\_\_\_\_

## BASIC FIRST AID: CARE AND COMFORT

First aid procedure(s): \_\_\_\_\_

Does student need to leave classroom after a seizure?     Yes     No

If yes, describe process for returning student to classroom: \_\_\_\_\_

### BASIC SEIZURE FIRST AID

- Stay calm and track time and duration of seizure
- Keep student safe
- Do not restrain or interfere with student's movements
- Do not put anything in student's mouth
- Stay with student until fully conscious

### FOR TONIC-CLONIC SEIZURE:

Protect student's head  
Keep airway open/watch breathing  
Turn student on side

## EMERGENCY PROCEDURES

Students with epilepsy will typically experience seizures as a result of their medical condition.

Call 9-1-1 when:

- Convulsive (tonic-clonic) seizure lasts longer than five (5) minutes.
- Student has repeated seizures without regaining consciousness.
- Student is injured or has diabetes.
- Student has a first-time seizure.
- Student has breathing difficulties.
- Student has a seizure in water
- \*Notify parent(s)/guardian(s) or emergency contact.

Refer to Appendix L – Policy Manual – Student Miscellaneous - S.M.19 Epilepsy

## HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

**Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.**

Healthcare Provider's Name: \_\_\_\_\_

Profession/Role: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.

\*This information may remain on file if there are no changes to the student's medical condition.



## AUTHORIZATION/PLAN REVIEW

### INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

	Yes (Please Initial for each)	No (Please Initial for each)
We, the Parents/Guardians/ Adult Student request the posting of this Individual Plan of Care in the:	School Staff Room	
	Elementary Homeroom Classroom	
	School Main Office	
We the Parents/Guardians/Adult Student request the sharing of this plan with individuals which include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff, and school bus drivers.		
We the Parents/Guardians/ Adult Student request the sharing of information on signs and symptoms of Epilepsy with students in the classroom.		
We, the Parents/Guardians/ Adult Student request the sharing of this Individual Plan of Care with the Before and After-School Program.		
We the Parents/Guardians/Adult Student consent to the carrying of the medication on his/her person.		
We the Parents/Guardians/Adult Student consent to the self-administration of medication.		

### TRANSPORTATION

School Bus Driver/Route # (If Applicable)

New Plan of Care

Updated Plan of Care

**This plan remains in effect for the 20\_\_ — 20\_\_ school year without change and will be reviewed on or before: \_\_\_\_\_.** (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year).

Parent(s)/Guardian(s):

Date:

Adult Student:

Date:

Principal:

Date: