Appendix A

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;

- 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 <u>To be completed by the attending physician when medication is initiated or changed</u>.

(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: __________________________________

IS-96-56 (To be placed in Documentation File of O.S.R)

Appendix C

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:
date date

Student's Name: ____________________________ Birthdate: (yyyy/mm/dd) ____________

School: ____
Medic Alert 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:

1. Name_______________________Telephone:_______________Relationship:_____________
2. Name_______________________Telephone:_______________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.

Appendix D

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

INDIVIDUAL EPILEPSY PLAN OF CARE

STUDENT INFORMATION

Student Name ________________ Date Of Birth _____________

Ontario Ed. # _________________ Age ____________________

Grade ______________________ Teacher(s) _______________

Student Colour Photo

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

<table>
<tr><td colspan="4">INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED</td></tr>
<tr><td colspan="2"></td><td>Yes (Please Initial for each)</td><td>No (Please Initial for each)</td></tr>
<tr><td rowspan="3">We, the Parents/Guardians/ Adult Student request the posting of this Individual Plan of Care in the:</td><td>School Staff Room</td><td></td><td></td></tr>
<tr><td>Elementary Homeroom Classroom</td><td></td><td></td></tr>
<tr><td>School Main Office</td><td></td><td></td></tr>
<tr><td colspan="2">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.</td><td></td><td></td></tr>
<tr><td colspan="2">We the Parents/Guardians/ Adult Student request the sharing of information on signs and symptoms of Epilepsy with students in the classroom.</td><td></td><td></td></tr>
<tr><td colspan="2">We, the Parents/Guardians/ Adult Student request the sharing of this Individual Plan of Care with the Before and After-School Program.</td><td></td><td></td></tr>
<tr><td colspan="2">We the Parents/Guardians/Adult Student consent to the carrying of the medication on his/her person.</td><td></td><td></td></tr>
<tr><td colspan="2">We the Parents/Guardians/Adult Student consent to the self-administration of medication.</td><td></td><td></td></tr>
<tr><td colspan="4">TRANSPORTATION</td></tr>
<tr><td colspan="4">School Bus Driver/Route # (If Applicable) □ New Plan of Care □Updated Plan of Care</td></tr>
<tr><td colspan="4">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).</td></tr>
</table>

Parent(s)/Guardian(s):	Date:
Adult Student:	Date:
Principal:	Date: