D155
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Enter with promise. Leave with purpose.

Authorization to Provide Seizure Care by a Delegated Care Aide, Acknowledgement of Responsibilities, and Release of Healthcare Information

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Student Name:_____**Grade:**_____

School: _____

Delegated Care Aide

As provided by the Illinois *Seizure Smart School Act*, 105 ILCS 150/1 *et seq.,* I hereby authorize Community High School District 155 and its employees, as well as any and all Delegated Care Aides named in my child's Seizure Action Plan or later designated by the District, to provide seizure care to my child, consistent with the child's Seizure Action Plan. I authorize the performance of all duties necessary to assist my child with management of his/her epilepsy care at school and school-sponsored activities in accordance with my child's Seizure Action Plan.

Acknowledgement of Responsibilities & Release of Information

I acknowledge that it is my responsibility to ensure that Community High School District 155 is provided with the most up-to-date and complete information regarding my child's epilepsy and treatment, including providing my child's school with a Seizure Action Plan detailing the health care provider's instructions for managing the child's epilepsy management at school, including orders, emergency care, and medications, and methods for administering those medications. In addition, I consent to the release of information about my child's epilepsy and treatment by my child's health care provider(s) identified below to Community High School District 155. I grant consent to the District to communicate and exchange any and all student record and medical information with the designated health care provider(s). I understand that the purpose of the disclosure is for educational planning and for providing services consistent with my child's Seizure Action Plan. If I do not grant this consent, the District will not exchange information with my child's health care provider(s), but I will not suffer any other consequences. This consent is valid for one calendar year from the date set forth below, and may be revoked at any time in writing. I also understand that I have the right to inspect, copy, and challenge the information to be disclosed pursuant to this consent. I further understand that the information in my child's Seizure Action Plan will be released to appropriate District employees and officials who have responsibility for or contact with my child and who may need to know this information for my child's health and safety.

Health Care Provider's Name (Print):_____

Phone Number:_____Fax Number:_____

Email:_____

Pursuant to Section 45 of the *Seizure Smart School Act* (105 ILCS 150/45), I acknowledge and agree that Community High School District 155 and its employees are not liable for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with epilepsy.

Parent/Guardian Signature: _____Date:_____

Failure of a parent/guardian to execute this form does not affect the civil immunity afforded the District and its employees by Section 45 of the Seizure Smart School Act (105 ILCS 150/45) for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with epilepsy, or any other immunities or defenses to which the District and its employees are otherwise entitled.