Agreement Regarding Food and Locks

To the best of my ability I understand that I have a medical disorder. The name of this medical disorder is Prader-Willi syndrome.

To the best of my ability I understand that two of the symptoms of this medical disorder are an insatiable appetite (hyperphagia) and the inability to feel full or recognize feeling full.

To the best of my ability I understand that for my own health and safety, my food must be managed properly.

I know that I will receive all of my authorized meals and snacks.

I want all of my care providers, including family members and professional staff, to always try to keep me safe.

Therefore, I authorize that all food items and beverage items and money be securely locked so that I cannot access them.

I do not waive this authorization even when the hyperphagia symptom causes me to become upset.

This agreement may only be changed during my Person-Centered Plan/Individual Program Plan at which my parent(s) and/or conservator is present.

Printed Name _____ Date _____

Signature _____

Witness _____ Date _____