SUBMIT THIS FORM TO Camp YouCan by August 4th!

CAMPER BACKGROUND FORM

Camper's Name: _____ Age: _____

Sex: ☐ Male ☐ Female Birth date: _____ Grade in school 2014/2015: _____

Parent(s)/Guardian: _____

Camper Address:

_____
Street

_____
City State Zip County

Camper's Home Phone: _____ Mother's Work Phone: _____

Current e-mail address: _____ Father's Work Phone: _____

Parent(s) cell phone: _____ _____

Emergency Contact (if parent(s) cannot be reached): _____
Name and relationship to camper

_____
Home Phone Work Phone

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Camper's Physicians (Please provide complete address and telephone):

Family physician or pediatrician:	Neurologist:
_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City State Zip	City State Zip
_____	_____
Phone	Phone

Which physician regularly treats your child's seizures? ☐ Neurologist ☐ Pediatrician

Social History: My child makes friends ☐ Easily ☐ Fairly easily ☐ With difficulty

What are the ages of your child's friends?_____ What do they do for fun? _____

_____

Would you describe your child's interactions with others as:

☐ Flexible & easygoing ☐ Structured, in need of routine

Does your child have any particular routines, habits, or rewards that are particularly meaningful to him/her?
☐ Yes ☐ No If yes, please describe _____

_____

Does your child have any significant emotional or behavioral issues (e.g. attention deficit disorder, episodes of physical aggression or violent behavior, depression, suicidal thoughts, etc.)? ☐ Yes ☐ No

If yes, please explain: _____

_____

What do you do to manage behavior when problems arise? _____

Does your child require constant one-on-one supervision? (If yes, please explain:) _____

_____

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Is your child comfortable talking about his/her seizures? ☐ Yes ☐ No

Does your child have any particular fears?

_____

Prefers to be with: ☐ Him/herself ☐ Older children ☐ Younger children ☐ Same age ☐ Adults

Are there any hygiene or special needs we should know about? _____

_____

Any specific activities to be encouraged or restricted? _____

Is your child approved to sleep on the top bunk if needed? ☐ Yes ☐ No

Appetite: ☐ Normal ☐ Above Normal ☐ Below Normal ☐ Picky

Is your child on the Ketogenic, Modified Atkins, or any other special diet? ☐ Yes ☐ No

Dietary modifications needed: _____

Health History:

How old was your child when first diagnosed with epilepsy or a seizure disorder?_____

Operations or serious injuries (dates): _____

Other chronic or recurring health problems: _____

Will your child be bringing any of the following to camp: glasses, contact lenses, hearing aid, retainer, prosthetic devices, helmet, braces, etc.?

☐ Yes ☐ No If yes, please specify: _____

(Although we will take every reasonable step to see that these are not lost or damaged, the camp cannot be responsible for any loss.)

Does your child use a VNS (Vagus Nerve Stimulator)? ☐ Yes ☐ No

Please check all that apply:

☐ Asthma
☐ Cerebral palsy
☐ Diabetes
☐ Mononucleosis
☐ Other: _____
☐ Frequent ear infections
☐ Heart defect/disease
☐ Bleeding/clotting disorders
☐ Hypertension
☐ Visually or hearing impaired
☐ **Developmental delay: Please provide details** _____

_____

Allergies:

☐ Hay fever ☐ Penicillin
☐ Poison ivy ☐ Other drugs: _____
☐ Insect stings ☐ Other allergies: _____
☐ Food (specify) _____

What is reaction to allergy? What is recommended response?

_____
_____

Will any emergency/specialized medications be brought to camp? (Epi-Pen, Inhaler, Nebulizer, Diastat, etc.)
☐ Yes ☐ No
If applicable, please bring asthma action plan or other specialized action plan used at school.

Seizure History:

YOU MUST COMPLETE THIS SECTION TO BE REGISTERED

When was the camp applicant diagnosed with seizures or epilepsy? _____

SEIZURE TYPE	USUAL FREQUENCY	HOW LONG DOES IT LAST?	ESTIMATED DATE OF MOST RECENT SEIZURE	BRIEF DESCRIPTION
#1			_ _ / _ _ / _ _ _ _	
#2			_ _ / _ _ / _ _ _ _	
#3			_ _ / _ _ / _ _ _ _	
#4			_ _ / _ _ / _ _ _ _	

Seizure History:

Does your child usually get a special warning prior to a seizure? ☐ Yes ☐ No If yes, please describe:
_____

Does your child lose bowel or bladder control during a seizure? ☐ Yes ☐ No

Typical things that may trigger a seizure (check any that apply):
☐ Lack of sleep ☐ Flashing lights ☐ Missed medication ☐ Menstruation ☐ Other_____

Special instructions during your child's seizures: (VNS, emergency meds)
_____

Special instructions for after the seizure (e.g. rest, sleep, special observations, etc.): _____

_____

Has the camper ever had Status Epilepticus? ☐ Yes ☐ No How many times? _____

What has been effective in treating your child when in status? _____

_____

Does your child require any special assistance? (For example, does your child require one-on-one care? Please explain) _____

_____

_____

****Important: If medications are to be administered at camp, ALL prescribed medications, including rescue medications, MUST be brought to camp in the original packaging from the pharmacy with the pharmacy prescription label and directions attached, readable and within the expiration date.**

Name of person completing form _____

Relationship to camper _____

Pick Up Information

Your child will be kept on camp grounds until you check in with camp staff and show picture ID. Please list the names of the people that will be allowed to pick up your child.

_____ _____

_____ _____

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PERMISSION FOR TREATMENT — *MUST BE COMPLETED FOR CAMP ATTENDANCE*

Parent's Authorization: This health history is correct to the best of my knowledge, and my child has permission to engage in all camp activities (boating, archery, ropes course, etc.) except as noted by me and/or the examining physician.

I give my permission to the medical personnel selected by camp to order of x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

I understand that while camper accident insurance is included in the camp fee, it does not cover any pre-existing health condition such as epilepsy. I take financial responsibility for any accident or illness directly related to my child's seizure disorder.

I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

_____ _____

Parent/Guardian Signature Date

_____

Relationship to Camper