



CAMPER BACKGROUND FORM

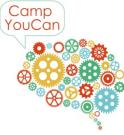
Camper's Name:		Age:	
Sex: Male Female	e Birth date:	Grade in school 2014/2015:	
Parent(s)/Guardian:			
Camper Address:			
Str	eet		
Cit	y S	State Zip County	
Camper's Home Phone:		Mother's Work Phone:	
Current e-mail address:		Father's Work Phone:	
Parent(s) cell phone:			
Emergency Contact (if page 2)	arent(s) cannot be reached):	d): Name and relationship to camper	
		Name and relationship to camper	
Home Phon	е	Work Phone	



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<u>Camper's Physicians</u> (Please provide <u>complete</u> address and telephone):

Family physician or pediatrician:			Neurologist:				
Name					Name		
Address					Address		
City	State	Zip			City	State Zip	
Phone			-		Phone		
Which physician reg	ularly tr	eats your ch	nild's se	eizures? 🗌	Neurologist] Pediatrician	
Social History:	My ch	nild makes fr	riends	☐ Easily	☐ Fairly easily	☐ With difficulty	
What are the ages o	f your c	hild's friends	s?	W	hat do they do for	fun?	
Would you describe ☐ Flexible & easyg				ith others a			
Does your child have ☐ Yes ☐ No						ticularly meaningful to him/	
Does your child have physical aggression						ention deficit disorder, epis ☑ Yes ☐ No	odes of
If yes, please explain	n:						
What do you do to m	anage	behavior wh	nen pro	blems arise	9?		
Does your child requ	ire con	stant one-or	n-one s	supervision?	(If yes, please ex	oplain:)	



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Is your child comfortable talking about his/her seizures?						
Prefers to be with: [☐ Him/herself ☐ Older children ☐ Younger children ☐ Same age ☐ Adults					
Are there any hygie	ne or special needs we should know about?					
Any specific activities	es to be encouraged or restricted?					
Is your child approv	red to sleep on the top bunk if needed?					
Appetite: Norma	I ☐ Above Normal ☐ Below Normal ☐ Picky					
Is your child on the	Ketogenic, Modified Atkins, or any other special diet? ☐ Yes ☐ No					
Dietary modification	ns needed:					
Health History:						
How old was your c	hild when first diagnosed with epilepsy or a seizure disorder?					
Operations or serio	us injuries (dates):					
Other chronic or rec	curring health problems:					
devices, helmet, bra	ringing any of the following to camp: glasses, contact lenses, hearing aid, retainer, prosthetic aces, etc.? Yes \[\sum \text{No} \text{If yes, please specify:} \]					
(Although we will take e	very reasonable step to see that these are not lost or damaged, the camp cannot be responsible for any loss.)					
Does your child use	e a VNS (Vagus Nerve Stimulator)? Yes No					
Please check all that	at apply:					
Asthma Cerebral Diabetes Mononuc Other: Develop	☐ Bleeding/clotting disorders					

YouCan OR OR OR OR OR OR OR OR OR O		Penic Other s Other ify) ergy? What is recomme	drugs: allergies:				
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 Histor	<u>y:</u>						
YOU MUST CO	MPLETE THIS	SECTION TO BE	REGISTERED				
When was the camp	p applicant diagnosed	d with seizures or epilep	sy?				
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 <u>during</u> 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.





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		