



HEALTH HISTORY (Please complete all that apply)

**Physicians**

Family Physician/Paediatrician \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Neurologist \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Which physician regularly treats your child's seizures? \_\_\_\_\_

Please list any additional health insurance that you have (carrier and policy number).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ontario Health Card Number     -    -

Please include a photocopy of your health card.

**Child's General Health**

Excellent

Average

Below Average

Tires Easily

When was your child's epilepsy first diagnosed? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Estimate the number of school days that your child missed during the last year due to epilepsy. \_\_\_\_\_

Have other reasons kept your child from school for more than 3 days at a time? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

SEIZURE SUMMARY

**Seizure One**

Type of seizure \_\_\_\_\_

Description of this seizure \_\_\_\_\_

\_\_\_\_\_

Average duration of this seizure \_\_\_\_\_

How often does your child have this type of seizure? \_\_\_\_\_

Any particular time of day? \_\_\_\_\_

When did your child last have this type of seizure? \_\_\_\_\_

**Seizure Two**

Type of seizure \_\_\_\_\_

Description of this seizure \_\_\_\_\_

\_\_\_\_\_

Average duration of this seizure \_\_\_\_\_

How often does your child have this type of seizure? \_\_\_\_\_

Any particular time of day? \_\_\_\_\_

When did your child last have this type of seizure? \_\_\_\_\_

**Other Seizure Information**

Does your child get any special warning before a seizure?     Yes     No

Please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Typical things which may trigger your child's seizures. (Please indicate all which apply)

- Lack of Sleep             Flashing Lights             Missed Medication
- Menstruation             Other:

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

Please describe any special instructions for assisting your child during a seizure. \_\_\_\_\_

Please describe any special instructions for assisting your child after a seizure. (Time to rest/sleep) \_\_\_\_\_

Has your child ever experienced status epilepticus?  Yes  No

If yes, how many times? \_\_\_\_\_ When was the last time? \_\_\_\_\_

What has been effective in treating your child when in status epilepticus? \_\_\_\_\_

### OTHER INFORMATION

#### **Sleep Habits**

Light  Heavy  Sleepwalker  Nightmares  Falls out of bed

My child usually goes to bed at: \_\_\_\_\_

My child usually wakes at: \_\_\_\_\_

My child functions best with \_\_\_\_\_ hours of sleep.

Please check any of the following which apply to this child.

- |  |  |
|--|--|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Frequent Ear Infections     |
| <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Heart Defect/Disease        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Bleeding/Clotting Disorders |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Other: _____                |

#### Allergies **\*Peanut-Free Camp\***

- |   |   |                                    |
|---|---|------------------------------------|
| <input type="checkbox"/> Bee Sting              | <input type="checkbox"/> Poison Ivy         | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Penicillin             | <input type="checkbox"/> Other Drugs: _____ |                                    |
| <input type="checkbox"/> Peanuts                | <input type="checkbox"/> Other Foods: _____ |                                    |
| <input type="checkbox"/> Other Allergies: _____ |   |                                    |

Please note the reaction your child has when exposed to the above stimulants. \_\_\_\_\_

Does your child wear glasses, contact lenses, hearing aid(s), retainer, etc.? \_\_\_\_\_

(Although every reasonable step will be taken to ensure that these items are not lost or damaged, Epilepsy Ontario and its Chapters cannot be held responsible for any loss or damage.)

**Childhood Diseases**

- Chicken Pox Year \_\_\_\_\_
- Chicken Pox Vaccine Year \_\_\_\_\_
- Mumps Year \_\_\_\_\_
- Measles Year \_\_\_\_\_
- German Measles (Ruebella) Year \_\_\_\_\_
- Other: \_\_\_\_\_ Year \_\_\_\_\_

List any major surgical operations and the dates of these operations. \_\_\_\_\_

**Immunization History**

Please record the date (month & year) of basic immunizations and most recent booster shots.

- DPT Series \_\_\_\_\_  Booster \_\_\_\_\_
- Polio OPV (Sabin) \_\_\_\_\_  Booster \_\_\_\_\_
- Measles (live) \_\_\_\_\_  Mumps Vaccine (live) \_\_\_\_\_
- German Measles (Ruebella) \_\_\_\_\_  Booster \_\_\_\_\_
- Tetanus \_\_\_\_\_  Booster \_\_\_\_\_
- Tuberculin Test \_\_\_\_\_  Other: \_\_\_\_\_

**Medications**

Note: You must supply your child's supply of antiepileptic medication(s) and any other prescribed medications

Child's Weight: \_\_\_\_\_ kg \_\_\_\_\_ lbs

**Seizure Medications**

Medication	Formulation & Dosage	Frequency
1.		
2.		
3.		
4.		

**Other Medications** (for asthma, allergies, etc.) Please list and describe reason for use

Medication	Formulation & Dosage	Frequency
1.		
2.		
3.		
4.		

**Headache Medications**

Medication	Formulation & Dosage	Frequency
1. Tylenol Regular		
2. Tylenol Extra		
3. Advil		
4. Other		

**Emergency Drugs**

Medication	Formulation & Dosage	Frequency
1. Ativan		
2. Paraldehyde		
3. Valium		
4. Other		

Any special instructions? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please remember to include a photocopy of your health card.*

CHILD'S PROFILE

How easily does your child make friends?     Easily     Fairly Easily     With Difficulty

Does your child have any emotional/behavioural problems? (Please explain.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you do to manage behaviour when problems arise? (Please explain.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child require one-on-one supervision? (Please explain.) \_\_\_\_\_

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Is your child comfortable talking about his/her seizures? (Please explain.) \_\_\_\_\_

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Does your child have special fears? (Please explain.) \_\_\_\_\_

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Appetite       Above Normal       Normal       Below Normal       Picky

Personality       Shy       Co-operative       A Leader       Independent  
 Happy       Withdrawn       A Follower       A Loner  
 Nervous       Aggressive       Other: \_\_\_\_\_

Other Comments: \_\_\_\_\_

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My child prefers to play with:     Self (alone)     Older Children     Younger Children     Same Age

Has your child been away from home without parents before? How was this experience? \_\_\_\_\_

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Has your child been to overnight camp before? How was this experience? \_\_\_\_\_

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Please indicate any activities that need extra supervision or modification, and how they should be modified.

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What is your child's swimming ability? \_\_\_\_\_

Should we encourage any specific activities with your child? \_\_\_\_\_

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Should we restrict or limit any specific activities with your child? \_\_\_\_\_

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Name of person completing this form: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

How did you hear about this camp? \_\_\_\_\_

PERMISSION FOR TREATMENT

*(Important!! This must be completed for attendance.)*

Parent's/Guardian's Authorization

This health history is correct to the best of my knowledge, and my child has permission to engage in all camp activities except as noted by the physician and me.

I give permission to the physician selected by the Camp Director to order treatment for the health of my child. In the event I cannot be reached in an emergency, I give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anaesthesia and/or surgery for my child as named above.

I take financial responsibility for any accident or illness directly related to my child including emergency transportation.

All information provided in this Participant Information & Medical Health Profile form is true and complete, to the best of my knowledge.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

*Please remember to include a photocopy of your health card.*