An integrated camping experience for children with seizure disorders.

**Sponsored by Epilepsy Ontario**

**2025 Participant Information & Medical Health Profile**

Please complete all forms and return with your deposit before the registration deadline to Camp Couchiching.

Camp Couchiching Tel: 705-325-3428

3990 Longford Mills Rd Fax: 705-325-7001

Longford Mills, ON L0K 1L0 Email: info@campcouchiching.com

All information will remain confidential. Please note that a copy of the forms will be sent to Anita Allen, retired RN from SickKids and Epilepsy Ontario for review. **Sponsorship applications available upon request**, please email Gula Aitkulova at gula@epilepsyontario.org.

**Camper Information**

Please note that there is a separate Registration Form which must also be submitted.

Camper’s Name: Surname First Name Initial

Street: Click or tap here to enter text.

City: Click or tap here to enter text. Province: Click or tap here to enter text.

Postal Code: Click or tap here to enter text.

Camper’s Date of Birth: (dd/mm/yyyy) Gender: [ ] Male [ ] Female

Camper’s Age: Click or tap here to enter text. Current Grade in School: Click to enter text.

Parent’s/Contact’s Name: Click or tap here to enter text.

Phone: Click or tap here to enter text. Business Phone: Click or tap here to enter text.

Cell Phone: Click or tap here to enter text.

**Emergency Contact**

Please indicate whom to contact if parents are not available in an emergency.

Important! Make sure that this person knows your desires and what to do in case of emergency.

Emergency Contact’s Name: Click or tap here to enter text.

Day Phone: Click or tap here to enter text. Evening Phone: Click or tap here to enter text.

**Health History** (*Please complete all that apply*)

**Physicians**

**Family Physician/Pediatrician:** Click or tap here to enter text.

Address Click or tap here to enter text. Phone: Click or tap here to enter text.

**Neurologist:** Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Which physician regularly treats your child’s seizures? Click or tap here to enter text.

Please list any additional health insurance that you have (carrier and policy number): Click or tap here to enter text.

Ontario Health Card Number  -  - 

**Please include a photocopy of your child’s health card**.

**Child’s General Health**

[ ]  Excellent [ ]  Average [ ]  Below Average [ ]  Tires Easily

When was your child’s epilepsy first diagnosed? Click or tap here to enter text.

Estimate the number of school days that your child missed during the last year due to epilepsy: enter text.

Have other reasons kept your child from school for more than 3 days at a time: Click or tap here to enter text.

**Seizure Summary**

**Seizure One**

Type of seizure: Click or tap here to enter text.

Description of this seizure: Click or tap here to enter text.

Average duration of this seizure: Click or tap here to enter text.

How often does your child have this type of seizure? Click or tap here to enter text.

Any particular time of day? Click or tap here to enter text.

When did your child last have this type of seizure? Click or tap here to enter text.

**Seizure Two**

Type of seizure: Click or tap here to enter text.

Description of this seizure: Click or tap here to enter text.

Average duration of this seizure: Click or tap here to enter text.

How often does your child have this type of seizure? Click or tap here to enter text.

Any particular time of day? Click or tap here to enter text.

When did your child last have this type of seizure? Click or tap here to enter text.

**Other Seizure Information**

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

Please describe: Click or tap here to enter text.

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: Click or tap here to enter text.

Please describe any special instructions for assisting your child after a seizure. (Time to rest/sleep): Click or tap here to enter text.

Has your child ever experienced status epilepticus? [ ]  Yes [ ]  No

If yes, how many times? Click or tap here to enter text. When was the last time? Click or tap here to enter text.

What has been effective in treating your child when in status epilepticus? Click or tap here to enter text.

Other Information

**Sleep Habits**

[ ]  Light [ ]  Heavy [ ]  Sleepwalker [ ]  Nightmares [ ]  Falls out of bed

My child usually goes to bed at: Click or tap here to enter text.

My child usually wakes at: Click or tap here to enter text.

My child functions best with Click or tap here to enter text. hours of sleep.

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

[ ]  Asthma [ ]  Frequent Ear Infections

[ ]  Cerebral Palsy [ ]  Heart Defect/Disease

[ ]  Diabetes [ ]  Bleeding/Clotting Disorders

[ ]  Developmental Delay [ ]  Other: Click or tap here to enter text.

**DRUG ALLERGIES**

Click or tap here to enter text.

Does your child wear glasses, contact lenses, hearing aid(s), retainer, etc? Click or tap here to enter text.

(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 Click or tap here to enter text.

[ ]  Chicken Pox Vaccine Year Click or tap here to enter text.

[ ]  Mumps Year Click or tap here to enter text.

[ ]  Measles Year Click or tap here to enter text.

[ ]  German Measles (Ruebella) Year Click or tap here to enter text.

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Click or tap here to enter text.

List any major surgical operations and the dates of these operationsClick or tap here to enter text.

**IMMUNIZATION HISTORY**

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

[ ]  DPT Series enter text. [ ]  Booster enter text.

[ ]  Polio OPV (Sabin) enter text. [ ]  Booster enter text.

[ ]  Measles (live)enter text. [ ]  Mumps Vaccine (live) enter text.

[ ]  German Measles (Ruebella)enter text. [ ]  Booster enter text.

[ ]  Tetanus enter text. [ ]  Booster enter text.

[ ]  Tuberculin Test enter text. [ ]  Other :enter text.

**MEDICATIONS**

**NOTE: YOU MUST SUPPLY YOUR CHILD’S SUPPLY OF ANTIEPILEPTIC MEDICATION(S) AND ANY OTHER PRESCRIBED MEDICATIONS**.

Child’s Weight: Click or tap here to enter text.kg Click or tap here to enter text.lbs

**Seizure Medications**

|  |  |  |
| --- | --- | --- |
| Medication | Formulation & Dosage | Frequency |
| 1.Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 2.Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 3.Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 4.Click here to enter text. | Click here to enter text. | Click to enter text. |
| 5.Click here to enter text. | Click here to enter text. | Click here to enter text. |

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

|  |  |  |
| --- | --- | --- |
| Medication | Formulation & Dosage | Frequency |
| 1.Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 2.Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 3.Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 4.Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Headache Medications**

|  |  |  |
| --- | --- | --- |
| Medication | Formulation & Dosage | Frequency |
| 1.Tylenol Regular | Click here to enter text. | Click here to enter text. |
| 2.Tylenol Extra | Click here to enter text. | Click here to enter text. |
| 3.Advil | Click here to enter text. | Click here to enter text. |
| 4.Other | Click here to enter text. | Click here to enter text. |

**EMERGENCY DRUGS**

|  |  |  |
| --- | --- | --- |
| Medication | Formulation & Dosage | Frequency |
| 1.Ativan | Click here to enter text. | Click here to enter text. |
| 2.Paraldehyde | Click here to enter text. | Click here to enter text. |
| 3.Valium | Click here to enter text. | Click here to enter text. |
| 4.Other | Click here to enter text. | Click here to enter text. |

Any special instructions? Click or tap here to enter text.

*Please remember to include a photocopy of your child’s 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.) Click or tap here to enter text.

What do you do to manage behaviour when problems arise? (Please explain.) Click or tap here to enter text.

Does your child require one-on-one supervision? (Please explain.) Click or tap here to enter text.

Is your child comfortable talking about his/her seizures? (Please explain.) Click or tap here to enter text.

Does your child have special fears? (Please explain.) Click or tap here to enter text.

**Appetite**  [ ]  Above Normal [ ]  Normal [ ]  Below Normal [ ]  Picky

**Personality** [ ]  Shy [ ]  Co-operative [ ]  A Leader [ ]  Independent

 [ ]  Happy [ ]  Withdrawn [ ]  A Follower [ ]  A Loner

 [ ]  Nervous [ ]  Aggressive [ ]  Other: Click here to enter text.

Other CommentsClick or tap here to enter text.

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? Click or tap here to enter text.

Has your child been to overnight camp before? How was this experience? Click or tap here to enter text.

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

What is your child’s swimming ability? Click or tap here to enter text.

Should we encourage any specific activities with your child? Click or tap here to enter text.

Should we restrict or limit any specific activities with your child? Click or tap here to enter text.

Name of person completing this form: Relationship to Camper: Click or tap here to enter text.

How did you hear about this camp? Click or tap here to enter text.

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

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 health care professional and me.

I give permission to the health care professional 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 health care professional 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