epilepsy ontario

# SUMMERFEST

An integrated camping experience for children with seizure disorders.
**Sponsored by Epilepsy Ontario**

## 2024 Participant Information & Medical Health Profile

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

Camp Couchiching
3990 Longford Mills Rd
Longford Mills, ON L0K 1L0

Tel: 705-325-3428
Fax: 705-325-7001
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 _____

City _____ Province _____

Postal Code _____

Camper's Date of Birth (dd/mm/yyyy) _____ Gender: ☐ Male ☐ Female

Camper's Age _____ Current Grade in School _____

Parent's/Contact's Name _____

Phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____

## 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 _____

Day Phone (____) _____ Evening Phone (____) _____

*Name of camper* _____

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

### Physicians

**Family Physician/Pediatrician** _____

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 child's 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? _____

_____

_____

*Name of camper* _____

## 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:

*Name of camper* _____

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.

☐ Asthma
☐ Cerebral Palsy
☐ Diabetes
☐ Developmental Delay
☐ Frequent Ear Infections
☐ Heart Defect/Disease
☐ Bleeding/Clotting Disorders
☐ Other: _____

### DRUG ALLERGIES

_____

_____

_____

_____

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

*Name of camper* _____

(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. | | |

*Name of camper* _____

| | | |
|---|---|---|
| 4. | | |
| 5. | | |

**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 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.) _____

_____

_____

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

*Name of camper* _____

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

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

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

**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: _____

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? _____

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

*Name of camper* _____

_____

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

_____

_____

What is your child's swimming ability? _____

Should we encourage any specific activities with your child? _____

_____

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

_____

_____

Name of person completing this form: Relationship to Camper: _____

How did you hear about this camp? _____

*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