**Kaleo’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ Gender: M, F**

**Session #: \_\_\_\_\_\_\_ Kamp: (please circle) 1, 2, 3**

**Group Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Kaleo’s Primary Dr.**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2nd Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**On Site Leader \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kamp: (please circle) 1, 2, 3**

**Note:** Any potential Kaleo with history of seizure activity should supply a Medical Doctor’s statement listing limitations and stating procedures to use in event of a seizure while at KAA kamps.     
   
KAA Kamp is a sports kamp located a minimum of one hour from emergency rooms/hospitals.  
   
Each person with a seizure history is responsible for bringing adequate supplies of all medication to be used for preventing or treating their seizure activity.   
   
**In the interest of safety, any person who has experienced any seizure activity in the past 12 months is ineligible to attend camp.   Exposure to hot weather, dehydration, increased physical activity, loud music and cheers, loud sounds, strobe lights, and other factors may precipitate seizures and are risk factors at Kamp for a person with a seizure history.**   
Seizure information with medical history must be received by Health Services at least 3 weeks prior to arrival of the registrant; **this is not negotiable and there will be no exceptions or deviations from this rule. Attendees who arrive to Kamp with an undisclosed seizure history will be sent home at the group’s expense.** If there are concerns by Health Services regarding information received you will be contacted prior to the start of your kamp session.

Kaleo’s Initials \_\_\_\_\_\_\_\_

A close up of a logo

Description automatically generated

**KAA Kaleo Seizure Policy**

**Kaleo Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ Gender: M, F**

**Session # \_\_\_\_\_\_\_\_\_ Kamp: (please circle) 1, 2, 3**

**Seizure Questionnaire for Kaleos with Seizures**

At what age were you diagnosed with seizures/epilepsy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of seizure have you experienced? **Please circle**:

**Tonic-Clonic**: Grand Mal **Absence**: Petit Mal **Complex**: Psychomotor/Temporal Lobe

**Simple**: Jacksonian/Focal Motor **Febrile**: high fever **Other**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last seizure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long did it last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you typically experience seizures? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the longest length of time your seizures have lasted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What symptoms typically precede your seizures? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you recognize these early warning signs? **Y/N** explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle symptoms you have with seizures**: Loss of consciousness, Falls, Muscle stiffness, Rhythmic convulsions,

Purposeless activity, aimless wandering, blank stare, fluttering eyelids, Twitching/jerking movements, repetitive acts,

Confusion, Loss of awareness, Unresponsive, Loss of control (bladder, bowel, drooling, etc.)

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

How do you react after seizures?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does you have any special needs after the seizure?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you receive emergency medications with seizures? **Y/N**

What medication and when given? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list medications taken on a regular basis: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Times taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a dose of routine medication is missed what procedure should be taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list additional information that would be helpful for preventing or treating your seizures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_