KAA Attendee Seizure Policy

Attendee Name: _____ DOB: _____ Age_____ Gender: M, F

Week: _____ Camp:(please circle) 1, 2, 3, HG, Kaleo Group Name:_____

Emergency Contact: (Parent/Guardian must be listed as the Primary Emergency Contact.)

Name: _____ **Phone #**_____

2nd Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Attendee's Primary Dr.: _____ **Phone #** _____

On Site Leader _____ Phone # _____ Camp: (please circle) 1, 2, 3

Note: Any potential attendee with history of seizure activity should supply a Medical Doctor's statement listing the following: limitations, environmental triggers and procedures to use in event of a seizure while at KAA camps.

KAA Camp is a sports camp 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 6 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 camp 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 camp 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 camp session.

Parent Initials _____

KAA
Kids Across America

Attendee Name: _____ DOB: _____ Age_____ Gender: M, F
Week: _____ Camp:(please circle) 1, 2, 3, HG, Kaleo

Seizure Questionnaire for Attendee with Seizures

Approximate date of diagnosis with seizures/epilepsy? _____

What type of seizure has the attendee experienced? **Please circle**:

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

Simple: Jacksonian/Focal Motor **Febrile**: High Fever **Other**: _____

When was the attendee's last seizure? _____ How long did it last? _____

How often does the attendee typically experience seizures? _____

What is the longest length of time the attendee's seizures have lasted? _____

What symptoms typically precede the attendee's seizures? _____

_____

Does the attendee recognize these early warning signs? **Y/N** explain: _____

Please circle symptoms attendee has 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 does the attendee react after seizures? _____

Does the attendee have any special needs after the seizure? _____

Does attendee 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 the attendees seizures:
_____

(Parent/Guardian) Signature: _____ Date:_____

Parent Phone: _____ (in case the pages become separated)