

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.) _____

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? _____

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? _____

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.