



# Seizure Information Form

If a participant has a seizure disorder, this form must be completed and signed before the participant is allowed to register for any programs. Complete each category and list any other information necessary to provide safe and enjoyable activities for the participant. **Please update this form whenever there is a change in the information and submit it with the registration form.** You will be asked to review and update this form on an annual basis.

<b>CONTACT INFORMATION</b>	Date Completed: _____
Participant Name: _____	Date of Birth: _____
Participant Phone: _____	Email: _____
Parent/Guardian: _____	Phone: _____
Other Emergency Contact Name: _____	Phone: _____
Participant Primary Care Doctor: _____	Phone: _____

## SEIZURE INFORMATION (select and describe applicable)

Seizure Type	Length	Frequency	Describe Seizures
<input type="checkbox"/> Absence (staring spell)			
<input type="checkbox"/> Simple Partial			
<input type="checkbox"/> Complex Partial			
<input type="checkbox"/> Atonic (drop)			
<input type="checkbox"/> Tonic-clonic			
<input type="checkbox"/> Other (explain):			

When was the participant diagnosed with seizures or epilepsy? \_\_\_\_\_

What might trigger a seizure in the participant? \_\_\_\_\_

List any symptoms prior to the onset of the seizure (i.e. smells, behavior change, sounds): \_\_\_\_\_

\_\_\_\_\_

When was the participant's last seizure? \_\_\_\_\_

*Participants who have had a seizure in the past 5 years will be assigned a 1:1 staff in aquatic programs.*

Are seizures controlled by medication?  Yes  No *If yes, please complete medication information on second page.*

Describe recent seizure patterns: \_\_\_\_\_

\_\_\_\_\_

How does the participant act after a seizure? \_\_\_\_\_

\_\_\_\_\_

How do other illnesses affect the participant's seizure control? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SEIZURE RECOVERY: FIRST AID, CARE AND COMFORT

Does the participant need to leave the program after a seizure?  Yes  No

List recovery and basic first aid procedures to be taken by staff: \_\_\_\_\_

\_\_\_\_\_

## SEIZURE EMERGENCIES

Describe what constitutes an emergency for this participant: \_\_\_\_\_

Has the participant ever been hospitalized for continuous seizures?  Yes  No

If yes, please explain: \_\_\_\_\_

### Seizure activity is considered an emergency and 911 will be called when:

- staff is unaware of a seizure disorder
- staff is uncomfortable with the situation
- a seizure is different than prior seizures
- a seizure lasts longer than 3 minutes
- the participant does not regain consciousness after seizure
- the participant stops breathing for longer than 30 seconds
- the participant complains of a sudden severe headache
- the participant sustains injuries just before or during a seizure
- the participant is pregnant or diabetic
- a seizure occurs in the water
- medication is required during a seizure (i.e. rectal diastat/diazepam/valium)

## SEIZURE MEDICATION AND TREATMENT INFORMATION

Current medication(s) for seizures:

*If medication is distributed during programs, additional medication dispensing forms will be required.*

Medication	Dosage	Frequency and Time of Day Taken	Possible Side Effects

What emergency/rescue seizure medication(s) are prescribed for the participant?

*Please note that invasive procedures such as the administration of rectal diastat/diazepam/valium are not able to be performed.*

Medication	Dosage	Administration Instructions (timing & method)

Does your child have a Vagal Nerve Stimulator?  Yes  No

If yes, please describe magnet use: \_\_\_\_\_

Additional information: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_