



# SEIZURE Individual Treatment Plan

Estes Park Center  
YMCA of the Rockies  
Youth Programs

Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Camp Week #: \_\_\_\_\_ Group: \_\_\_\_\_

**THIS CAMPER IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BECOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING CAMP HOURS.**

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Significant medical history: \_\_\_\_\_

### SEIZURE INFORMATION:

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

Seizure triggers or warning signs: \_\_\_\_\_

Camper's reaction to seizure: \_\_\_\_\_

### BASIC FIRST AID: CARE & COMFORT:

(Please describe basic first aid procedures)

Does camper need to leave the group or activity after a seizure?  YES  NO

\*If YES, describe process for camper returning to group or activity:

### EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

**Seizure Emergency Protocol:** (Check all that apply and clarify below)

- Contact camp nurse
- Call 911 for transport to \_\_\_\_\_
- Notify parent/guardian or emergency contact
- Notify doctor
- Administer emergency medications as indicated below
- Other: \_\_\_\_\_

**TREATMENT PROTOCOL DURING CAMP HOURS:** (include daily and emergency medications)

<i>Daily medication</i>	<i>Dosage &amp; Time of Day Given</i>	<i>Common Side Effects &amp; Special Instructions</i>

Emergency/Rescue Medication information

Does the camper have a **Vagus Nerve Stimulator (VNS)**?  YES  NO

**SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:** (regarding camp activities, sports, etc.)

\_\_\_\_\_  
Parent/ Legal Guardian Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

Email this completed form to: [daycampepc@ymcarockies.org](mailto:daycampepc@ymcarockies.org) or Fax to Youth Programs: 970-577-1255

Phone: 970-586-3341, ext. 1280