# SEIZURE ACTION PLAN

Effective Date________

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

Participant's Name:_________________________________ Date of Birth:_________

Parent/Guardian:______________________________ Phone: _____________Cell:_______________

Treating Physician:____________________________ Phone: _____________

Significant medical history:_______________________________________________________

## SEIZURE INFORMATION:

| *Seizure Type* | *Length* | *Frequency* | *Description* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Seizure triggers or warning signs:_______________________________________________

Participant's reaction to seizure:_______________________________________________

## BASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

Does participant need to leave the group after a seizure? YES NO

If YES, describe process for returning participant to group

**Basic Seizure First Aid:**
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

## EMERGENCY RESPONSE:

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

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

- ☐ Contact camp nurse at ______________________________
- ☐ Call 911 for transport to ____________________________
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other________________________________________________

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Participant has repeated seizures without regaining consciousness
- ✓ Participant has a first time seizure
- ✓ Participant is injured or has diabetes
- ✓ Participant has breathing difficulties
- ✓ Participant has a seizure in water

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

| Daily Medication | Dosage & Time of Day Given | Common Side Effects & Special Instructions |
|---|---|---|
| | | |
| | | |

Emergency/Rescue Medication

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

If YES, Describe magnet use____________________________________________

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

**Physician Signature:**_____________________________________**Date:**______________

**Parent Signature:**_______________________________________**Date:**______________

# MONMOUTH COUNTY PARK SYSTEM
## MEDICATION AUTHORIZATION FORM

**Participant's Name:** ________________________________________ **Date of Birth:** ____________

We highly recommend and encourage that medications be administered prior to or after the camp session, however; we recognize that there may be occasions where medicine may need to be administered with supervision during the camp day. Any medication <u>other than</u> rescue medications (benadryl with epi-pen, epi-pen, or asthma inhaler) will only be administered with supervision at a location where a camp nurse is present such as Dorbrook Recreation Area.

1. All prescription and non-prescription medication (over the counter) require a physician's authorization and shall be labeled and stored in the original prescription container.
2. All medication is maintained under staff supervision and the staff supervises the administration of this medication. The only exception to this is Asthma inhalers, which may be carried on the person, but must be clearly labeled with doctor's protocol.
3. Parents/Guardians must sign the medication authorization form below.

**<u>Parental Request</u>**

I, the parent/guardian of ____________________________________ request that the rescue/prescription medication prescribed by my child's physician be administered to my child by a trained staff member (for rescue medications only such as epi-pens, benadryl with epi-pens or asthma inhalers) or the camp nurse (for other prescribed medications for campers at Dorbrook Recreation Area). The medication will be brought to camp in its original container appropriately labeled by my pharmacy.

____________________________________________ ___________________________
Signature of parent/guardian Date

____________________________________________ ___________________________
Address Home Phone Number

__________________________ ______ _______________ ___________________________
City State Zip Cellular Number

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**<u>Physician's Authorization</u>**

In order to protect the health of, ______________________________ it is necessary for him/her to have the Following medication during camp hours.

MEDICATION: ____________________________________________________________________

DOSAGE: ________________________________________________________________________

TIME to be administered: ____________________________________________________________

Purpose of medication: ______________________________________________________________

List any possible side effects: ________________________________________________________

I authorize the camp nurse or qualified staff member to administer the above medication.

Signature of Physician ______________________________________________ Date ____________

Address ____________________________________________________________________________