Adult Summer participant checklist

- ☐ Information form
- ☐ Case manager information
- ☐ Billing paperwork
- ☐ Schedule dates form
- ☐ Physical form (signed by doctor) ***TB test required***
- ☐ Medication form (if applicable)
- ☐ Transportation request form (if applicable)
- ☐ My seizure response (if applicable)
- ☐ Verify with case manager your participant is ready to start
- ☐ Registration fee ($75 non-member/ $0 member)

Parent signature _____ **Date:** _____

2021 Information Form

Please keep a copy of this form for your records

PARTICIPANT INFORMATION UPDATES		
Participant Name:		
Address:		
City, St, Zip:		
Phone (daytime):		**E-Mail:**
DOB:	**Age:**	☐ **Negative TB Test date**_____
Diagnosis:		☐ **Physical release date**_____
Takes Medication at Program? Yes No **Has an Epi Pen** Yes No		**T-shirt ADULT:** **S** ☐ **M** ☐ **L** ☐ **XL** ☐ **XXL** ☐ **XXXL** ☐

☐ Same as participant	PARENT/GUARDIAN INFO	CASE MANAGER/FUNDER
Name		
Home Phone #		
Cell #		
E-mail		

Release and Hold Harmless Agreement

As a participant in the program of the RecPlex, owned and operated by the Village of Pleasant Prairie, I recognize and acknowledge that there are certain risks of physical injury, and I agree to assume the full risk of any injuries, damages, or losses, which I may sustain as a result of participating in all activities connected with or associated with such program. I agree to relieve and relinquish all claims: I have as a result of participating in the program, against the Village of Pleasant Prairie and its officers, agents, and employees. I do hereby fully release and discharge the Village of Pleasant Prairie and its officers, agents, and employees from any and all claims from injuries, damages, or losses, which I may have or may accrue to me on an account of my negligence during participation in the program. I agree to indemnify and hold harmless and defend the Village of Pleasant Prairie and its officers, agents, and employees from all claims result from injuries, damages, and losses sustained during and arising out of the activities of the program.

Coronavirus/COVID-19 Warning & Disclaimer

Coronavirus, COVID-19 is an extremely contagious virus that spreads easily through person-to-person contact and air particles. Federal and state authorities recommend social distancing as a mean to prevent the spread of the virus. COVID-19 can lead to severe illness, personal injury, permanent disability, and death. Participating in RecPlex programs or accessing RecPlex/Village of Pleasant Prairie facilities could increase the risk of contracting COVID-19. RecPlex in no way warrants that COVID-19 infection will not occur through participation in RecPlex programs or accessing RecPlex facilities. As a condition of my participation or my child's participation in the RecPlex programs, I accept any risk of infection from COVID-19. I specifically release and hold harmless the Village of Pleasant Prairie RecPlex from any losses, damages, or personal injury to myself, my child, or my household from participation in any RecPlex programming.

I have read and understand the Release and Hold Harmless Agreement and the COVID-19 Warning and Disclaimer. I understand that my signature is required to take part in RecPlex programs. If the participant is under the age of 18, a parent or guardian signature is required.

IN CASE OF MEDICAL EMERGENCY,

Froedert **Aurora** **Kenosha Campus** **Other**_____

Photo Release: I do hereby consent and agree to allow the RecPlex to use my camper's image or likeness in photos, videos, or audio for educational or promotional purposes, including posting on the internet. I agree that the use herein is done so without compensation. Please initial _____ I DO NOT grant permission to take photos of my camper _____

Field Trip: I DO authorize my camper to travel to and from program events via program transportation. Please initial _____

I DO NOT authorize my camper to travel offsite for program events or field trips: Please initial _____

My student will be attending 5 half days or a minimum of 3 or more full days per week. Absences for excused absences should be received at least a week in advance. Absences due to illness or medical will be excused along with planned vacations. Excessive missed attendance can result in termination of care.

ATTENDANCE						
MONDAY	AM RESPITE	HALF	AM PM	FULL	PM RESPITE	AM/PM TRANS
TUESDAY	AM RESPITE	HALF	AM PM	FULL	PM RESPITE	AM/PM TRANS
WEDNSDAY	AM RESPITE	HALF	AM PM	FULL	PM RESPITE	AM/PM TRANS
THURSDAY	AM RESPITE	HALF	AM PM	FULL	PM RESPITE	AM/PM TRANS
FRIDAY	AM RESPITE	HALF	AM PM	FULL	PM RESPITE	AM/PM TRANS
SATURDAY	RESPITE TIME _____			TRANSP – 1st & 3rd Sat of the month		

ITEMS REQUIRED AT REGISTRATION:

1. Information form - 2021
2. Medical release – valid for 1 year
3. TB test results, must be negative – valid for 2 years
4. Paid registration fee – FREE if a RP member, otherwise $75 for school year, $75 for summer
5. Dates of Attendance form – **Fall 2020, Spring 2021 or Summer 2021**

BEHAVIOR GUIDELINES/EXPECTATIONS: Safety of all our participants and staff is our first concern. Our camp is set up to support campers who may need assistance in participating. We do not condone aggression towards other campers or staff. Our ratio is 4:1, therefore this camp may not be appropriate for every camper. Please keep that in mind when choosing the summer camp for your camper.

1. Keep your hands to yourself.
2. Show appropriate social behavior with peers & staff. (No spitting, hitting, kicking, scratching, pinching, etc)
3. Use appropriate language. (no swearing, yelling at others)
4. Respect your friends, your staff and yourself!
5. Participate in activities and have fun.

Clients who have difficulty following the rules will be warned about their behavior. Clients who are physical or aggressive towards other campers or staff will be sent home for the first occurrence, out for a week for the second occurrence and removed completely for the third occurrence. We reserve the right to remove a client at any time if deemed a danger to self or others.

Parent/Guardian Signature _____ Date _____

HEALTH INFORAMTION & BACKGROUND

Disability(s): _____ _____

Check or list any condition a staff member should know about:

Heart Condition	___	Seizures	___
Diabetic	___	Eye Infections	___
Allergic to bee stings	___	Glasses/contacts	___
Allergic to medication	___	Headaches	___
Allergic to latex	___	Dietary restrictions	___
Food Allergy	___	Participation limits	___

Other _____

ALLERGIES:
Food Allergies: _____
Medication Allergies: _____
_____
_____
_____

Record of immunizations and date of last tetanus shot: _____

	MOBILITY		ATTENTION		TOILETING*
	Ambulatory		Typical Attention span		Toilets independently
	Uses Wheelchair		Needs transition assistance		Needs prompting/reminders
	Wears braces		Runs/Wanders		Needs assistance/supervision
	Needs assistance walking/stairs		Is easily distracted		Needs assistance with wiping
	Needs assistance in pool		Needs to be active		Uses toilet schedule (please supply)
	Needs assistance in bathroom		Needs frequent rests		Uses briefs (please supply 1 week at a time)

*We have both female and male staff. We typically have the same gender staff assist with toileting but if needed, an opposite gender staff may assist with toileting.

	PERSONAL CARE		MEALS		COMMUNICATION
	Can dress independently		Able eater		Communicates verbally
	Needs some assistance		Needs some help/prompting		Uses communication aid
	Needs complete assistance		Drinks with a straw		Uses sign language
	Needs help with shoes/tying		Takes food from others		Needs 1-2 step directions
	Needs help with shower/soap		Uses special utensils (please label)		Unable to communicate needs
	Needs help with deodorant		Difficulty chewing/swallowing		Non-verbal but can make needs known

*If g-tube fed, please attach a written feeding schedule including times and amounts.
* Any medically prescribed meals we should know about or food restrictions?

	BEHAVIOR & SAFETY	
	Best way to transition	
	Best way to redirect	
	Best way to calm	
	Behaviors when upset	
	Fears/triggers/phobias	
	Behavior Plan YES NO	If yes, please provide behavior plan.

Please list if there are any activities specifically not liked/enjoyed._____
_____

Other information not asked but we should know _____
_____

☐ NO behavior concerns

	Behavior Concerns				
	Is self-abusive		Runs away/wanders		
	Abusive towards others		Difficulty with transitions		
	Bites (self or others)		Does not like loud noises		
	Scratches/pinches self or others		Does not like to be touched		
	Grabs others		Enjoys social time		
	Uses inappropriate language		Prefers activities alone		
	Uses inappropriate touch		Inappropriate sexual behavior		

Please do not be offended if we ask for photo identification from you or others who pick-up your child.
This is for the safety of all participants in our care.

Emergency Contact – people authorized to pick up your loved one, within 20 minutes of RecPlex
(Parents are always authorized to pick up, but we may ask for ID until all staff are familiar.)

Name	Relationship	Daytime Phone Number

The following are NOT authorized to pick-up my child:

Name	Relationship	Daytime Phone Number

GOALS: Please list 1-3 goals that can be worked on during the year.

1. _____

_____

2. _____

_____

3. _____

_____

Adult Case Manager Information form

Funder: _____

Case manager name: _____

Case manager e-mail: _____

Case manager phone number: _____

authorization must be on file prior to starting program

CONTACT INFORMATION

Contact information for any 3rd party membership or adult billing or program questions:

Maggie: Mkent@pleasantprairiewi.gov OR 262-925-6753

Contact information for any youth billing questions, respite information or adult program questions:

Bethany: Bpfeiffer@pleasantprairiewi.gov OR 262-947-3661

Contact information for any program questions, respite information, availability

Erin: Ewinch@pleasantprairiewi.gov OR 262-925-6747

DISCOVERY ADULT & YOUTH
Payment Form/ Automatic Enrollment/ Payment Options

Please fill out completely to avoid delays in reserving space!

Parent/Guardian Full Name:

Email Address:

May RecPlex contact email for promotions? YES NO

Summer/Fall Registration Fee: $75.00 per participant (Non-refundable).
Field Trips and Misc.: You will be informed of any field trips or other special occasions via email or flyers.
Registration and any associated fees will be added to your weekly billing. Additional forms (i.e.: field trip permission slip) may also need to be submitted in conjunction with each event. An email address is required to complete this form.

SELECT ONE OPTION BELOW (Your payment option will be sued for all listed participants.)

Option 1: Weekly Bank Draft

Checking Account #:

Routing #:

Percentage paid by guardian: %

Percentage paid by 3rd party agency: %

- Funds will be withdrawn from your checking account each Friday.
  If selecting a checking account, a voided check is required to start this option.
- You must note what percentage you are paying if you have a 3rd party agency paying a portion of your bill.

Option 2: Weekly Credit Card Payment

Cardholders Name (print):

C.C Financial Institution (bank name on credit card):

Card Type (circle): VISA MASTERCARD DISCOVER AMEX

Credit Card #:

Expiration Date:

Billing Address:

Percentage paid by guardian: %

Percentage paid by 3rd party agency: %

- Funds will be charged to your credit card each Friday.
- You must note what percentage you are paying if you have a 3rd party agency paying a portion of your bill.

I hereby authorize the RecPlex and the financial institution designated to begin automatic deductions from the account designated for Discovery Program participants listed on this form. I understand I will be charged weekly. I have provided the type of payment (credit card or checking account). I understand that my monthly bank statement will typically show the amount and the date payment was made to the RecPlex. I understand that I am responsible for ensuring that the account designated for the weekly auto withdrawal has sufficient funds to cover my payment. I understand that if there are any changes to my account I will notify the RecPlex Business Manager in writing 1 week prior to my scheduled weekly automatic payment deduction. I understand I am liable for any uncollected payment and for any fees or penalties imposed by the RecPlex or my financial institution related to any uncollected payment.
I am the parent/guardian and agree to the terms of this document.

Account Holder Signature:

Date:

Option 3: 3rd Party Billing

3rd Party Agency Auto Enrollment/Payment

☐ Check Here

I, registrant, understand that my child's care is being billed to a 3rd party agency. I, registrant, understand that if at any time the 3rd party agency no longer pays my child's care I am responsible for any outstanding balance due. I, registrant, understand that I am required to notify the RecPlex Discovery Program of any changes to my child's 3rd party payment coverage.

☐ Initial Here

Percentage paid by guardian: _____ %

_____ %

- This option allows you to select from one of the 2 payment options and note the percentage to be billed, to you each Friday, using the checking account or credit card provided in option 1 or 2.
- If your child's care is covered 100% by a 3rd party agency you must initial this option and sign the registration agreement section. Noting 100% paid by a 3rd party agency.

Registration Agreement

I agree to the policies and procedures set forth in the RecPlex Discovery Program. I give permission for my child to take field trips and be transported to and from RecPlex in buses and Village vehicles. I will be notified in advance when any field trips take place. RecPlex has my permission to use any photographs of my child taken during the program or during any activity the program sponsors for the purpose of display or publicity.

Emergency Treatment: I grant RecPlex permission to administer emergency treatment to my child. This may include, but is not limited to, emergency first aid, local rescue or local hospital/trauma center.

Agreement: I understand this registration form is a contract for child care on specific days and weeks and that I am liable for the cost regardless of whether or not my child attends. I agree to pay RecPlex my weekly tuition in advance. I understand that there is no credit given for absences, vacations or holidays. Further, I am responsible for payment of all days and weeks that I have indicated or added. One (1) week's advance notice is required in writing to change my child's schedule or withdrawal from the program. I understand I am liable for charges billed if one week's notice is not given for any changes in scheduled attendance or withdrawal from the program.

Payment: Payments are due no later than the Friday prior to the first day of attendance for the payment period. The registrant, (parent or guardian who signs form) agree to make payments to Village of Pleasant Prairie/RecPlex no later than the due date or pay an additional $10 weekly per late payment. Returned checks or declined credit card payments will incur a $25 fee, plus you will be required to make payment in full for past due amounts in addition to one week's tuition in advance before readmitting your child to the program.

By completing and signing the Registration forms, I, the registrant, understand and agree to the terms, policies and guidelines set forth in the RecPlex Discovery Policies flyer and Registration forms. I agree to be responsible for all costs incurred with collecting debts more than 30 days past due, including but not limited to, fees for late payments, uncollected payments, filing fees, court costs, and attorney's fees.

By signing below you understand and agree to Village of Pleasant Prairie/RecPlex' payment terms and authorize Village of Pleasant Prairie/RecPlex to process your payments weekly prior to your child's participation in the program. Village of Pleasant Prairie/RecPlex will securely maintain your financial information. Parents/Guardians are responsible for updating with RecPlex any changes to their payment information, including credit card number, expiration date, card verification number, and billing address changes.

☐ Check Here - I have read and agree to Discovery Program Policies and Registration Forms.

Account Holder Signature: _____ Date: _____

DISCOVERY ADULT & YOUTH
Participant Information

CHILD #1 INFORMATION:

Full Name:	Age:	Circle One: Adult Youth

Program Options (Full Days - choose program option and circle days, Half Days - choose time)

5-Day	Full Day	M	TU	W	TH	F
3-Day	Full Day	M	TU	W	TH	F
2-Day	Full Day	M	TU	W	TH	F
5-Day	Half Day	AM	PM			

CHILD #2 INFORMATION:

Full Name:	Age:	Circle One: Adult Youth

Program Options (Full Days - choose program option and circle days, Half Days - choose time)

5-Day	Full Day	M	TU	W	TH	F
3-Day	Full Day	M	TU	W	TH	F
2-Day	Full Day	M	TU	W	TH	F
5-Day	Half Day	AM	PM			

Third Party Billing – SUMMER 2021

Client Name: _____

Funder Contact & Number: _____

Third party clients must have an authorization or proof of funding prior to registering for the summer session. This documentation can be sent via e-mail to ewinch@plprairiewi.com or bpfeiffer@plprairiewi.com. We require and bill based on 3 full days per week or 5 half days per week (AM or PM) Please select your times (AM, PM or FULL) and then your dates of attendance. We do grant 2 weeks of vacation over the summer for those attending regularly. All others are scheduled in based on availability from regular campers.

Program times are from 8am -5pm. Arrival or departure after those times will result in additional respite charges. Those needing transportation must submit a transportation request.

	AM	PM	Full	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week: 0 May 24-28									Respite
Week 1: June 1-4				NO PROGRAM HOLIDAY					Respite
Week 2: June 7-11					Last day of school	Soft camp start			Respite
Week 3: June 14-18				FIRST OFFICIAL DAY OF CAMP					Respite
Week 4: June 21-25									Respite
Week 5: June 28 – July2									NO RESPITE HOLIDAY
Week 6: July 5-9				NO PROGRAM HOLIDAY					Respite
Week 5: July 12-16									Respite
Week 6: July 19-23									Respite
Week 7: July 26-30									Respite
Week 8: Aug 2-6									Respite
Week 9: Aug 9-13									Respite
Week 10: Aug 16-20									Respite
Week 11: Aug 23-27									Respite
Week 12: Aug 30- Sept 3						KUSD Starts	Before and Afterschool	Before and Afterschool	NO RESPITE HOLIDAY
				NO RESPITE HOLIDAY					

_____

Parent/Guardian Signature *Date*

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-20810 (Rev. 08/2008)

STATE OF WISCONSIN

MEDICAID WAIVER PROGRAM HEALTH REPORT

Use of form: Personally identifiable information collected on this form is confidential and will be used for identification purposes and to document the individual's health information necessary in determining eligibility for services. Completion of this form is necessary to meet the requirements of Wis. Stats. 46.27(11) and 46.277(4).

Instructions: Complete within 90 days (before or after) the Waiver Start Date and annually within 90 days (before or after) the Waiver recertification month for each CIP II or COP-W participant.

A. TO BE COMPLETED BY CARE MANAGER

Name – Participant (Last, First, MI) | Date of Birth (mm/dd/yyyy)

Name – County Agency / Care Manager

Name – Physician / Clinic / Office | Physician's Telephone Number

B. TO BE COMPLETED BY PHYSICIAN OR REGISTERED NURSE

1. Describe participant's diagnosis (i.e., disabilities / impairments / rehabilitation potential / prognosis). List primary diagnosis first. If necessary, attach additional documentation.)

1a. Condition is considered: ☐ Stable ☐ Unstable (Check one.)

2. List name of medications, dosage and frequency. Include injections, prescription and over-the-counter medications ordered. If necessary, attach additional documentation.

2a. ☐ Yes ☐ No Medications should be supervised. (Check one.)

3. Physician's Orders

a. Therapies / home health (Check all that apply.)

☐ Home nursing care
☐ Occupational therapy
☐ Physical therapy
☐ Home health aide
☐ Speech therapy
☐ Assistance with housekeeping / chores
☐ Personal care
☐ Other

b. Treatments

☐ Oxygen
☐ Dialysis
☐ IV meds
☐ Decubiti care
☐ Ventilator
☐ Ostomy care
☐ Suctioning
☐ Transfusions
☐ Chemotherapy
☐ Catheter – Type: _____
☐ Feeding tube
☐ Parenteral / IV
☐ Severe pain
☐ Radiation
☐ Range of motion
☐ Other – List below.

4. Ongoing diagnostic tests required – type and frequency

5. Diet / nutrition – List special instructions

SIGNATURE – Physician, Physician Assistant or Registered Nurse | Date Signed

CARE MANAGER – See page 2

C. COMPLETION OF ITEMS 1 AND 2 BELOW ARE OPTIONAL.

If part C is completed, the information should be provided by the care manager, nurse or another professional familiar with this applicant / participant. Enter information not found on the Long Term Care Functional Screen or the Assessment / Supplement, or that is missing from page one of this form.

1. Describe mobility / activity limitations. List DME or adaptive aids needed.

2. Other relevant information: Mental status, orientation, communication, social abilities, special health needs or other applicant / participant-specific information that substantiates the level of care determination.

Name – Person filling out part C	Title

AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS

Use of form: This form is mandatory for family child care centers to comply with DCF 250.07(6)(f)1.a. Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers, day camps and certified providers; however, completion of this form meets the requirements of DCF 251.07(6)(f)1.a., DCF 252.44(6)(e)1.a. and DCF 202.08(4)(f) and 202.09(5)(c)., Wis. Admin. Codes. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: When a parent is requesting prescription or non-prescription medication be administered to a child in care, this form shall be completed and signed by the parent or guardian before any medication is administered. A separate form shall be used for each medication. Place form in child's file when medication is no longer required / authorized.
Licensed Child Care Centers: Log the dates and times medication was administered in the center medical log. Blanket authorizations that exceed the length of time specified on the label are prohibited; no medication intended for use by a child in the care of the center may be kept at the center without a current medication administration authorization from the parent.

A. FACILITY AND CHILD INFORMATION

Name – Child Care Center

Name – Child

Birthdate (mm/dd/yyyy)

B. MEDICATION INFORMATION: Medication shall be in the original container and labeled with the child's name. The label shall include dosage and directions for administration.

Name – Medication	Dosage	Time(s) of Day to be Administered	How to be Administered	Dates – Medication Time Period	
				From	To
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			

☐ Yes ☐ No **Does the over-the-counter (OTC) medication label indicate the child's physician should be consulted?** If "Yes" I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation.

Name – OTC Medication

Parent Initials

Additional information / special instructions / contraindications – Specify.

C. AUTHORIZATION

I hereby authorize administration of the above medication to my child by staff of the child care center listed above.

SIGNATURE – Parent or Guardian

Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education
DCF-F (CFS-0059) (R. 02/2009)

Documentation of Medication Administration – Certified Child Care Providers

Instructions: This section is to be completed only by certified child care providers to document the actual administration of the medication. Licensed child care centers do not complete this portion of the form because documentation of the administration of medications must be entered into the center medical log on the day that the medication is administered. Record administration of the authorized medication in the spaces provided below. Lines should not be skipped.

	Date Administered	Time Administered	Dosage	Signature / Initials of Person Who Administered the Medication
1.				
2.				
3.				
4.				
5.				
6.				
7				
8.				
9				
10.				
1				
2.				
3				
4				
5				
6				
7.				
3.				
9				
)				

TR Transportation Request

Please print and fill this form out completely.

Information about person needing transportation:

Last Name: _____ First Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Emergency Contact other than home within in 30 miles: _____
Name Phone Number

Special Handling – Check all that apply:

___ Wheelchair ___ Physical Disability ___ Behavior ___ Visually Impaired

___ Harness ___ Hearing Impaired ___ Seizures Other _____

Transportation Schedule Information: Please allow a minimum of 3 days for processing:

Requested start date for transportation: _____
Month Day Year

Requested end date for transportation: _____

Days requested for transportation (please circle): Monday Tuesday Wednesday Thursday Friday

Is there a specific time that you need to be picked up by? Please specify _____ AM or PM

Transportation Schedule:

Do you need transportation from home to RecPlex? YES or NO

Pick up time at home: _____ AM or PM

Do you need transportation from RecPlex to home? YES or NO

Pick up time at RecPlex: _____ AM or PM

Office Use Only:

Pick-up Time: _____ AM or PM Location: _____

Drop-off Time: _____ AM or PM Location: _____

Date Service Began: _____/_____/_____

Date Service Ended: _____/_____/_____

Transportation Request Received On:

My Seizure Response Plan

EPILEPSY FOUNDATION

Name: _____ Birth Date: _____

Address: _____ Phone: _____

1st Emergency Contact /Relation: _____ Phone: _____

2nd Emergency Contact / Relation: _____ Phone: _____

Seizure Information

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

Triggers

_____

_____

Daily Seizure Medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other Seizure Treatments

Device Type: _____ Model: _____ Serial# _____ Date Implanted _____

Dietary Therapy: _____ Date Begun: _____

Special Instructions: _____

_____

Other Therapy: _____

_____

continued on back

Seizure First Aid

- ☐ Keep calm, provide reassurance, remove bystanders
- ☐ Keep airway clear, turn on side if possible, nothing in mouth
- ☐ Keep safe, remove objects, do not restrain
- ☐ Time, observe, record what happens
- ☐ Stay with person until recovered from seizure
- ☐ Other care needed: _____

Call 911 if...

- ☐ Generalized seizure longer than 5 minutes
- ☐ Two or more seizures without recovering between seizures
- ☐ "As needed" treatments don't work
- ☐ Injury occurs or is suspected, or seizure occurs in water
- ☐ Breathing, heart rate or behavior doesn't return to normal
- ☐ Unexplained fever or pain, hours or few days after a seizure
- ☐ Other care needed: _____

When Seizures Require Additional Help

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"As Needed" Treatments (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

Health Care Contact

Epilepsy Doctor: _____ Phone: _____

Nurse/Other Health Care Provider: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Primary Care: _____ Phone: _____

Pharmacy: _____ Phone: _____

Special Instructions: _____

_____

My signature _____ Date _____

Provider signature _____ Date _____

EPILEPSY FOUNDATION

12/2016 130SRP/PAB1216