



**FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY**

**Date** \_\_\_\_\_ **SEIZURES**  
Sessions: \_\_\_\_\_ PVW \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5  
SP Camp \_\_\_\_\_

**Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

Known Allergies: \_\_\_\_\_ NKA

My **SEIZURE SYMPTOMS** are:

|  |
|--|
| _____ Mild – daydreaming in appearance   |
| _____ Moderate – some spastic muscle movement                                  |
| _____ Intense – spastic muscle contractions, possible incontinence, may vomit. |
| _____ Unclassified – febrile, occasional with no patterns, unknown             |

**Action steps** for when I have a seizure:

|  |
|--|
| <ul style="list-style-type: none"><li>• <b>Signal to WATCH for :</b> _____</li><li>• _____</li><li>• Protect me from harm. Help me to the floor/ground. Be sure there is nothing near to hurt me. Turn my head to the side, if needed (drooling, food,etc).</li><li>• Move the other children out of the way so no one will be hurt.</li><li>• After the seizure: reassure me, I am OK.<ul style="list-style-type: none"><li>* Assist me to change my clothes if necessary;</li><li>* Have me lay down to rest/sleep if desired</li></ul></li><li>• Other:<br/>_____</li></ul> |
|--|

Additional plan for me:

|  |
|--|
| See information above: Notify parent/legal guardian.<br>Notify Camp Director<br>Complete Medication Administered form. |
|--|

Additional information:

\_\_\_\_\_

Parent Signature:

\_\_\_\_\_ Date: \_\_\_\_\_

**MERIDEN YMCA**

110 West Main Street Meriden, CT 06451

**P** 203-235-6386 **F** 203-634-6517

**www.meridenymca.org**

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Nurse Name/Signature: \_\_\_\_\_

Date: \_\_\_\_\_

| Print Name | Signature | Date | Print Name | Signature | Date |
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