Seizure Action Plan & Summer Camp Clearance

Patient Name: [Patient First and Last Name]

Date of Birth: [MM/DD/YYYY]

Date of Last Physical: [MM/DD/YYYY]

Medical Clearance

I hereby certify that the above-named patient is under my care for a seizure disorder. They are medically cleared to participate in all standard summer camp activities, including swimming and physical sports, with the following restrictions: [Insert Restrictions or write None].

Seizure Information

Type of Seizures: [e.g., Focal, Generalized Tonic-Clonic, Absence]

Typical Signs/Symptoms: [e.g., Staring, shaking, loss of consciousness]

Average Duration: [e.g., 2 minutes]

Frequency: [e.g., Monthly, Yearly]

Seizure First Aid Protocol

- Stay calm and track the time the seizure began.
- Keep the patient safe; move sharp objects and cushion the head.
- Do NOT put anything in the patient's mouth.
- Turn the patient on their side to keep the airway clear.
- Stay with the patient until they are fully awake and alert.

Emergency Intervention (Rescue Medication)

Administer Rescue Medication if: [e.g., Seizure lasts longer than 5 minutes or 3 seizures occur in one hour]

Medication Name: [Insert Medication Name]

Dosage/Route: [e.g., 5mg Nasal or Rectal]

Call 911 If:

- The seizure lasts longer than [X] minutes.
- A second seizure starts shortly after the first.
- The patient has difficulty breathing or does not wake up.
- The seizure occurs in water.

Current Daily Medications

[List medications, dosages, and times to be administered at camp]

Physician Contact Information

Physician Name: [Name of Doctor]

Clinic/Hospital: [Name of Facility]

Phone Number: [Phone Number]

Physician Signature: _____

Date: [Current Date]