



Seizure Information Sheet and Checklist

We ask the parents/guardians submit a completed Seizure Information Sheet and any other required forms at least 7 days before the participant's first day of program. This allows staff time to make accommodations and train appropriate personnel.

Parent/Guardian Checklist:

Before the participant's first day of attendance, the parent/guardian/designee is responsible for training selected members of the Park District staff, including but not limited to, the Program Manager, and the program staff on the following:

- ☐ Provide the Program Manager with written medical documentation, instructions, and medications as directed by a physician, using the Seizure Information Sheet (attached).
- ☐ Provide properly labeled medications and replace medications after use or upon expiration.
- ☐ Prescription medications are reviewed and updated regularly by a physician.

All Park District staff that may have contact with the participant will be trained to know:

- Events/substances that may trigger a seizure
- Limitations on the participant that may help prevent a seizure.
- Symptoms of a seizure.
- When and how to administer treatment for a seizure.

The Park District cannot administer rectal medication during a seizure. This type of personal medical service is outside our scope, as we do not have licensed medical professionals on staff. Unlike public schools, our recreational programs are not equipped or funded to provide medical services of this nature. Courts in Illinois have also found that administration of rectal Diastat is not a required accommodation in recreational settings.

In the event of a seizure, our staff will call 911 and then attempt to reach you and/or your emergency contact. While we can store the medication for use by paramedics or a parent, there will be a delay in its administration.

Please note our staff is not trained to assess medical emergencies. One option your family may consider is providing a trained companion at your expense. If you choose this, the companion must complete a Park District registration form but will not be charged a program fee.

You may also continue enrollment with the understanding that the Park District cannot administer this medication. The safety of all participants remains our top priority.

Parent/Guardian's Signature: _____ **Date:** _____

Seizure Information Form

If a participant has a seizure disorder, this form must be completed and signed before the participant is allowed to register for any programs. Complete each category and list any other information necessary to provide safe and enjoyable activities for the participant. Please update this form whenever there is a change in the information and submit it with the registration form. You will be asked to review and update this form on an annual basis.



PROGRAM NAME: _____ **DATE COMPLETED:** _____

CONTACT INFORMATION

Participant Name: _____ Date of Birth: _____

Participant Phone: _____ Email: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Seizure Information

Seizure Type	Length	Frequency	Describe Seizures
☐ Absence (staring spell)			
☐ Simple Partial			
☐ Complex Partial			
☐ Atonic (drop)			
☐ Tonic-clonic			
☐ Other (explain):			

When was the participant diagnosed with seizures or epilepsy? _____

What might trigger a seizure in the participant? _____

List any symptoms prior to the onset of the seizure (i.e. smells, behavior change, sounds): _____

When was the participant's last seizure? _____

Participants who have had a seizure in the past 5 years will be assigned a 1:1 staff in aquatic programs.

Are seizures controlled by medication? ☐ Yes ☐ No (If yes, please complete medication information on second page.)



Describe recent seizure patterns: _____

How does the participant act after a seizure? _____

How do other illnesses affect the participant's seizure control? _____

SEIZURE RECOVERY: FIRST AID, CARE, AND COMFORT

Does the participant need to leave the program after a seizure? ☐ Yes ☐ No

List of recovery and basic first aid procedures to be taken by staff: _____

SEIZURE EMERGENCIES

Describe what constitutes an emergency for this participant: _____

Has the participant ever been hospitalized for continuous seizures? ☐ Yes ☐ No

If yes, please explain: _____

Seizure activity is considered an emergency and 911 will be called when:

- Staff is unaware of a seizure disorder
- Staff is uncomfortable with the situation
- A seizure is different than prior seizures
- A seizure lasts longer than 3 minutes
- The participant does not regain consciousness after seizure
- The participant stops breathing for longer than 30 seconds
- The participant complains of a sudden severe headache
- The participant sustains injuries just before or during a seizure
- The participant is pregnant or diabetic
- A seizure occurs in the water
- Medication is required during a seizure (i.e. Rectal diastat/diazepam/valium)



SEIZURE MEDICATION AND TREATMENT INFORMATION

Current medication(s) for seizures:

If medication is distributed during programs additional medication dispensing forms will be required.

Medication	Dosage	Frequency and Time of Day Taken	Possible Side Effects

What emergency/rescue seizure medication(s) are prescribed for the participant?

Please note that invasive procedures such as the administration of rectal diastat/diazepam/valium are not able to be performed.

Medication	Dosage	Administration Instructions (timing & method)

Does the participant have a Vagal Nerve Stimulator? ☐ Yes ☐ No

If yes, please describe magnet use: _____

Additional Information: _____

Parent/Guardian Signature: _____ Date: _____



Dispensing Medication Authorization

This form must be completed for each program session, for each medication, and/or when medication changes.

Program Name: _____ Date Completed: _____

PARTICIPANT INFORMATION

Participant's Name: _____ Age: _____

Address: _____ City/State/Zip: _____

Parent/Guardian Name: _____ Cell Phone: _____

MEDICATION INFORMATION

Medication Name: _____ Prescription #: _____

Dosage Instructions: _____

Frequency Medication Must Be Administered: _____

Time Medication Must Be Administered: _____

Possible Side Effects: _____

Dispensing and Storage Instructions: _____

Does the child have any limitations which will occur due to the listed medication? ☐ Yes ☐ No

Other Information: _____

I understand that it is my responsibility to give the medication directly to program manager with full instruction in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.

I authorize Glencoe Park District to administer specific medication listed above.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication change.

Parent/Guardian Signature: _____ Date: _____

