Tuberous Sclerosis Summer Camp

Medical Information

Seizure Type: _____

Current Seizure frequency: ____daily____weekly____monthly ____yearly or less

Recent need for Diastat or other rescue medications: _____

Number of times per week (on average) rescue medicine is needed?_____

Is the camper autistic? _____yes _____no

Please rate severity of autism: _____mild (such as aspergers) _____moderate _____severe

Please rate ability to interact with peers & staff:

_____great interaction (gets along well with same age peers)

_____okay interaction (sometimes has inappropriate interaction but does okay)

_____poor social skills (often has inappropriate responses, has few friends)

_____unable to interact (poor eye contact, little to no interaction with others)

_____my child wanders and/or runs away from the group

Please rate severity of behavioral and/or psychiatric issues:

_____mild (needs minimal redirection and/or time out)

_____moderate (frequently requires redirection and may be aggressive at times)

_____severe (often aggressive, may need 1:1 aide)

Current grade in school: _____ On an IEP/504 Plan: _____yes _____no

Please comment on activities of Daily Living:

_____eats & drinks well without assistance

_____able to take a shower on his/her own

_____needs supervision to take a shower

_____he/she is able to get dressed on own

_____he/she needs assistance getting dressed.

Comments: _____

Medications – current	Dosage	Times given

Previous medications and response (including Ketogenic Diet, seizure meds, behavioral medications)

Medications- previous	Response to medication

I agree to allow staff from the Tuberous Sclerosis Clinic to administer the medications listed at the frequency listed to my child who is not able to self-administer his/her medications. In the event that my child is in need of over-the-counter medications, I authorize staff from the Tuberous Sclerosis Clinic and/or Camp Joy to administer over-the-counter medication when appropriate with any exceptions listed below:

Over-the-counter medications/treatments my child may receive:
Treatment for sunburn: _____
Ointment for bug bites: _____
Sunscreen: _____
Bug spray: _____
Ibuprofen: _____
Acetaminophen: _____
Other: _____

Over-the-Counter medications/treatment my child may not receive:
_____
_____

_____ _____
Signature: Parent/Legal Guardian Date