EPILEPSY FOUNDATION
Greater Chicago

Women's Retreat Weekend Application Packet

The Women's Retreat Application Packet includes the following sections:
- Participant Information *(pages 1-5)*
- Women's Retreat Consent & Release *(page 6)*
- Medical Consent Form *(page 7)*
- Seizure Action Plan *(page 8)*

To Participants: Please follow the instructions below. ***Attach requested information.***
1. The Women's Retreat Application Packet must be completed in its entirety. Please print all answers legibly. If a question does not apply, answer "n/a" in the space provided.
2. Complete pages 1, 2, 3, 4, 5 and 6. Make a copy and submit to EFGC.
3. Provide pages 7 and 8 to your healthcare provider for completion. Make a copy and submit to EFGC.

Please mail, fax or email **completed** forms to the address below **BY SEPTEMBER 27, 2019**:

Epilepsy Foundation of Greater Chicago
ATTN: Leia Der
17 N. State Street, Suite 650
Chicago, IL 60602

F: (312) 939-0391
E: Lder@epilepsychicago.org

Participant Information

First Name: _____ Last Name: _____

Gender: ☐ Female ☐ Male Birth Date: _____ /_____ /_____ Age: _____

Home Address: _____
Street Address *City* *State* *Zip Code*

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email Address: _____

Primary Physician: _____ Neurologist: _____

P: _____ F: _____ P: _____ F: _____

Medical Insurance Information

I am covered by medical/hospital insurance ☐ Yes ☐ No

Insurance Company: _____ Policy Number: _____

Include a copy of your medical insurance card; copy both sides of the card so information is readable

Emergency Contact Information (*Participants are required to list two emergency contacts)*

Primary Emergency Contact

Name: _____

Relationship to Participant: _____

Home Phone: _____

Cell Phone: _____

Secondary Emergency Contact

Name: _____

Relationship to Participant: _____

Home Phone: _____

Cell Phone: _____

General Health & Seizure Information

Allergies: ***Check all that apply***

☐ Food (*If yes, please list food and describe the reaction):* _____

_____

_____

☐ Medication (*If yes, please list medication(s) and describe the reaction):* _____

_____

_____

☐ Other (*If yes, please list allergies and describe the reaction):* _____

_____

_____

Do you carry/use an EpiPen? ☐ Yes ☐ No

Diet: ***Check all that apply***

☐ Regular Diet ☐ Dairy Free ☐ Gluten Free ☐ Ketogenic ☐ Modified Atkins Diet ☐ Vegetarian ☐ Vegan

☐ Other (*If yes, please describe):* _____

Dietary Restrictions: _____

Additional Information: _____

Mobility:

Can walk independently ☐ Yes ☐ **No, *please explain*:** _____

Uses wheelchair ☐ No ☐ **Yes, *please explain*:** _____

Uses orthopedic equipment *(walker, braces, canes, AFOs)*: ☐ No ☐ **Yes, *please explain:*** _____

_____

Communication: ***check all that apply***

☐ Independent communication ☐ Hearing device/aid ☐ Uses sign language

☐ **Other, *please explain*:** _____

Additional Information:

_____

_____

_____

_____

Seizure Information:

Seizure Type	*Length*	*Frequency*	*Description*
Absence			
Focal Aware (Simple Partial)			
Focal Impaired (Complex Partial)			
Atonic			
Tonic-clonic			
Other (explain):			

When was your last seizure?: _____

What might trigger a seizure?: _____

_____

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

_____

List any changes in recent seizure patterns: _____

_____

How do you act after a seizure?: _____

_____

How do other illnesses affect your seizure control?: _____

_____

Are seizures controlled by medication? ☐ Yes ☐ No

Current medication(s):

Medication	*Dosage*	*Frequency and Time of Day Taken*	*Possible Side Effects*

Are you prescribed any emergency/rescue seizure medication(s)?: ☐ Yes ☐ No

Emergency medication(s) for seizures:

Medication	*Dosage*	*Administration Instructions (timing & method)*	*What to do after administration*

SEIZURE RECOVERY: FIRST AID, CARE AND COMFORT:

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

_____

Describe what constitutes an emergency for you: _____

_____

_____

Have you ever been hospitalized for continuous seizures? ☐ Yes ☐ No *If yes, please explain* _____

_____

_____

Please describe any other health problems that you have (diabetes, medication side effects, etc.): _____

_____

_____

_____

Are there any blood or body fluid precautions?: ☐ Yes ☐ No

Please provide any additional information about your health that you think is important or that may affect your ability to fully participate in the retreat program: _____

_____

_____

_____

Participant Acknowledgement

I can participate in the Women's Retreat Weekend without any restrictions

☐ Yes

☐ **No, *please explain:*** _____

_____

_____

_____

I am able to manage my medication and self administer

☐ Yes

☐ **No, *please explain assistance needed:*** _____

_____

_____

_____

I can participate in daily living activities such as using the bathroom, bathing/showering, eating, walking and dressing independently

☐ Yes

☐ **No, *please explain assistance needed*:** _____

_____

_____

_____

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

WOMEN'S RETREAT WEEKEND CONSENT & RELEASE

PLEASE READ THIS SECTION CAREFULLY BEFORE SIGNING, and be aware that in signing up and participating in this program, and using the facilities and equipment, you will be waiving and releasing all claims for injuries or loss or property damage that you might sustain arising in any manner out of this program or the use of the facilities or equipment. This section must be signed by the participant (if over 18) or parent/guardian or they will not be allowed to participate in this program or use the facilities or equipment.

PHOTOGRAPHIC RELEASE – In consideration of the furtherance of the purpose of Camp Nageela Midwest, Inc., the Epilepsy Foundation of Greater Chicago and the Epilepsy Foundation of America, I hereby grant permission to the same, their officers, agents, and employees to take photographs or video of me and to use and distribute for publication any and all such photographs, video, news releases, and stories for any purpose they may deem proper. In granting such permission, I hereby relinquish any right, title, and interest I may have in such photographs, video, news releases, and stories and grant Camp Nageela Midwest, Inc., the Epilepsy Foundation of Greater Chicago and the Epilepsy Foundation of America the right to use these products.

ACKNOWLEDGEMENT OF RISK OF INJURY CLAUSE – As a participant in the program, I recognize the risk and acknowledge that there are certain risks of physical injuries, including death, damages, property damage, or loss which I may sustain as a result of participating in any and all activities connected with such program or the use of the facilities or equipment.

WAIVER OF CLAIM FOR INJURY CLAUSE – I agree to waive and relinquish all claims that I may have for injuries or damages, as a result of participating in the program or using the facilities or equipment, against Camp Nageela Midwest, Inc., Epilepsy Foundation of Greater Chicago, the Epilepsy Foundation of America, and their officers, agents, servants, employees, and affiliates.

RELEASE FROM LIABILITY CLAUSE – I do hereby fully release and discharge Camp Nageela Midwest, Inc., the Epilepsy Foundation of Greater Chicago, the Epilepsy Foundation of America, and their officers, agents, servants, employees, and affiliates from any and all claims for injuries, including death, damages, property damage, or loss which may have or which may in the future accrue to me on account of participation in the program or use of the facilities or equipment.

INDEMNITY AND DEFENSE CLAUSE – I further agree to indemnify and hold harmless and pay defense costs and defend Camp Nageela Midwest, Inc., the Epilepsy Foundation of Greater Chicago, the Epilepsy Foundation of America, and their officers, agents, servants, employees, and affiliates, from any and all claims resulting from injuries, including death, damages, property damage, or loss sustained by me (or my family members) and arising out of, connected with, or in any way associated with the activities of the program or the use of the facilities or equipment. The undersigned, in case of emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment of family members by a physician or hospital selected by the Camp Director. Such permission shall include any and all medical treatment, which is necessary or desirable in the absolute discretion of any such physician or hospital. The undersigned recognizes the right of the Camp Director, in his/her absolute discretion, to terminate a camp family's stay at any time due to disciplinary or medical actions which might jeopardize the camper's or other's health, safety, or well-being at camp.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

MEDICAL CONSENT FORM

THE MEDICAL CONSENT FORM AND SEIZURE ACTION PLAN MUST BE COMPLETED BY MEDICAL PERSONNEL

Please mail/fax this form to the address below **BY SEPTEMBER 27, 2019**:

Epilepsy Foundation of Greater Chicago
ATTN: Leia Der
17 N. State Street, Suite 650
Chicago, IL 60602
FAX: (312) 939-0391

PATIENT INFORMATION

Name: _____
First *Middle* *Last*

☐ **Female** ☐ **Male** **Birth Date:** ____/____/____

Patient Home Address: _____

_____

PATIENT HEALTH-CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

- ***Please review and complete all remaining sections of the Medical Consent Form & Seizure Action Plan***
- ***Please print all answers legibly and attach additional information if needed***
- ***The Medical Consent Form & Seizure Action Plan must be completed in its entirety***
- ***If a question does not apply, answer "n/a" in the space provided***

The patient is undergoing treatment at this time for the following conditions: _____

_____

_____

_____

_____

It is my opinion that the patient is physically and emotionally fit to participate in an active weekend retreat program

☐ Yes ☐ **No, *please explain*:** _____

_____

_____

_____

Name of Treating Physician (please print): _____

Signature: _____ Title: _____

Office Address: _____
Street Address *City* *State* *Zip Code*

Phone: (_____)_____ Fax: (_____)_____ Date:_____

SEIZURE ACTION PLAN

Patient's Name: _____ Date of Birth: ____ /____ /_____

Emergency contact: _____ Phone: _____ Cell: _____

Treating Physician: _____ Phone: _____ Fax: _____

Significant medical history: _____

_____

Seizure Information

Seizure Type	*Average length*	*Average Frequency*	*Description*

Patient triggers or warning signs: _____

_____

_____

Patient reaction to seizure: _____

_____

_____

BASIC FIRST AID: CARE & COMFORT: *Please describe basic first aid procedures*

_____

_____

EMERGENCY RESPONSE:
A "seizure emergency" for this patient is defined as:

_____

_____

_____

Seizure Emergency Protocol: *Check all that apply and clarify below*

- ☐ Notify emergency contact
- ☐ Call 911 for transport to _____
- ☐ Notify doctor
- ☐ Administer emergency medications indicated below
- ☐ Other _____

TREATMENT PROTOCOL:

Daily/Rescue Medication	*Dosage & Time of Day Given*	*Common Side Effects & Special Instructions*

Does patient have a Vagus Nerve Stimulator (VNS)? ☐ YES ☐ NO

If YES, Describe magnet use: _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: (regarding activities, daily living, etc.) _____

_____

Name of Physician: _____
Physician Signature: _____
Date: _____

Name of Patient: _____
Patient Signature: _____
Date: _____