RECORD OF SEIZURE

Student: ______________________ D.O.B. ____/____/____ Grade: ______________

Address: ____

Parent/Guardian Name(s): ______________________ School: ______________

Home Phone: ______________ Work Phone: ______________________

Physician: ______________________ Phone: ______________

Date seizure occurred ___/___/___ Time seizure started __________ Time seizure ended __________

THE FOLLOWING OBSERVATIONS OCCURRED:

(Complete all that applies)

BEFORE

- list loud noises, strong smells, changes in lighting that may have occurred before the seizure:

____

____

DURING (Check all that apply)

____ eyes dilated
____ eyes rolled back
____ eyes shaking back and forth
____ facial twitching
____ changes in color of lips
or face to __________
____ increased drooling
____ lip smacking
____ chewing motions

____ change in breathing rate
(circle those that apply) Rapid Slow Shallow Deep
____ bowel movement during
____ urination during
____ vomiting before/during/after
____ upper body jerking only
____ lower body jerking only
____ one side of body jerking
____ left ____ right

OTHER ____

____

AFTER

____ BM after seizure
____ urination after seizure
____ lethargic/tired/sleepy

____ confused
____ crying
____ uncoordinated

____ headache
____ speech difficulties
____ weakness of arms/legs

OTHER ____

____

INTERVENTION PROVIDED BY SCHOOL STAFF: ______________________

____

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______________________________ ______________________

Signature of Reporting Staff Member *Date*