

## Seizure Observation Record

Student's name: \_\_\_\_\_

Date & time					
Seizure Length					
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)					
Conscious (yes/no/altered)					
Injuries (briefly describe)					
Muscle Tone/Body Movements	Rigid/clenching				
	Limp				
	Fell down				
	Rocking				
	Wandering around				
	Whole body jerking				
Extremity Movements	(R) arm jerking				
	(L) arm jerking				
	(R) leg jerking				
	(L) leg jerking				
	Random Movement				
Color	Bluish				
	Pale				
	Flushed				
Eyes	Pupils dilated				
	Turned (R or L)				
	Rolled up				
	Staring or blinking (clarify)				
	Closed				
Mouth	Salivating				
	Chewing				
	Lip smacking				
Verbal Sounds-describe (gagging, talking, throat clearing, etc.)					
Breathing-describe (normal, labored, stopped, noisy)					
Incontinent (urine or feces)					
Post-Seizure Observation	Confused				
	Sleepy/tired				
	Headache				
	Speech slurring				
	Other				
Length to orientation					
Parents notified? (note time of call)					
EMS called? (note call and arrival time)					
Observer's Name					

*Please put additional notes on back as necessary.*