

Seizure Report

Name: _____

Date: _____

Seizure started: _____ am/pm (leave blank if this is unknown)

Seizure ended: _____ am/pm

Seizure lasted: _____ min _____ sec (give approximate time even if start time is unknown)

The person was observed: _____ from start to end of seizure
_____ after the seizure began

What was the person doing before the seizure:

_____ walking _____ other: _____
_____ sitting _____ not known
_____ lying in bed

Description of seizure activity: place a number beside each symptom in order that it occurred

Body movements:

_____ Eyes Staring
_____ Eyes Moved to Left / Right (circle)
_____ Lip Smacking/Chewing
_____ Jaw Clenched
_____ Became Limp
_____ Fell

Skin Changes:

_____ flushed (red/purple)
_____ turned blue/gray
_____ excessive sweating
_____ skin cool, clammy
_____ other _____

Tonic (muscle spasm/rigid):

_____ left arm
_____ left leg
_____ right arm
_____ right leg
_____ trunk / torso

Did person become incontinent? Yes / No.

If yes, did they: urinate / defecate?

Clonic (jerky, rhythmic movement):

_____ left arm
_____ left leg
_____ right arm
_____ right leg
_____ trunk / torso

Other unusual behavior: _____

Level of consciousness:

_____ lost contact/awareness of surroundings (won't respond to stimulation or named when called)
_____ unconsciousness (passed out)
_____ no change in level of consciousness

If lost contact or become unconscious, how long did it last? _____ min _____ sec

What happened after the seizure?

_____ person became alert : How long after seizure? _____ min _____ sec
_____ person resumed his/her prior activities
_____ person seemed confused
_____ person seemed agitated
_____ person was drowsy/fell asleep

Injuries:

Any injuries received? Yes / No
If yes, described the injury: _____

Was an incident report completed? Yes / No
Did the person go to the hospital? Yes / No

Name of witness/person completing seizure report: _____