RECORD OF SEIZURE ACTIVITY

Name: _____ Date of seizure: _____
Start time: _____AM PM Stop time: _____AM PM Elapsed time: _____
Location at time of seizure: _____
What was the person doing? _____
DURING THE SEIZURE:
Did you see the beginning of the seizure? □ yes □ no
What was the first behavior you observed? _____
Was the whole body involved? □ yes □ no
If 'no', which part was involved? □ facial ticking □ arms twisting □ legs twisting,
□ drooling □ other: _____
Did the person talk or cry out during the seizure? □ yes □ no
If 'yes', please describe: _____
Observations during the seizure: (check all appropriate)

Eyes:	Skin:	Incontinence:
□ rolled upward	□ hot & dry	□ bladder
□ eyes closed	□ hot & sweating	□ bowel
□ looked to the side – right	□ cold & clammy	
□ looked to the side – left	□ pale	
□ eye lids fluttered	□ flushed	
□ eyes wide open	□ Cyanotic (bluish)	

Did the person lose conscienceness? □ yes, □ no If 'yes', how long? _____
AFTER THE SEIZURE:
Status after the seizure: □ alert □ drowsy □ confused □ agitated other: _____
Complaints: □ headache □ weakness □ paralysis other: _____
Was the person able to verbalize? □ yes □ no □ non-verbal person
Were injuries sustained as the result of the seizure? □ yes □ no
If 'yes', please describe: _____
Did this seizure differ from previous seizures that the person has had? □ yes □ no
If 'yes', please describe: _____
Who was notified? _____
COMMENTS: _____
_____
_____
_____
Incident Report completed? □ yes, only if seizure was unusual from others or longer than 3 minutes

Staff observing: _____
signature title

Reviewed by: _____
signature title

Distribution of Original & Two (2) Copies

- Original: To incident manager
- 2 Copies: (1) to Coordinator & (1) to Administrative Nurse