

# Seizure Observation Record



Student 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 (gagging, talking, throat clearing, etc.)			
Breathing (normal, labored, stopped, noisy, etc.)			
Incontinent (urine or feces)			
Post-Seizure Observation	Confused		
	Sleepy/tired		
	Headache		
	Speech slurring		
	Other		
Length to Orientation			
Parents Notified? (time of call)			
EMS Called? (call time & arrival time)			
Observer's Name			

*Please put additional notes on back as necessary.*