Form 13: SEIZURE RECORD

MEDICATIONS			
Date	Name of RX	Dose	Time

Student Name_____ Date of Birth_____

School Site _____Teacher Name _____

NOTE: CALL 911 **and** notify nurse if there is a change in the duration, frequency, or pattern of the seizures. Notify nurse immediately if seizure last more than 5 minutes, if there is a impairment of breathing, or if a child continues to go in and out of seizures.

DATE	TIME	DURATION Min/Sec (Use Your Watch)	BODY			EYES					No Response to Verbal Stimuli	Response to Pain	Fall During Seizure	INCONTINENT of URINE or BM	SKIN COLOR					SLEEPING Afterward (How Long?)	COMMENTS (eg. Child's comments, aura, sequence of events, child has cold or fever, any injury if fall, recent RX change, etc.)
			Stiffening	Jerking	Wet, Limp	Rolling Back	Staring	Nystagmus	Turn to side	Pupil					Blue Lips	Grayish	Paler	Flushed	No Change		