

Bellevue School District -- SEIZURE OBSERVATION RECORD - 3418P Exhibit C

Student Demographics and Health History					
Date:	Time:	School Name			
Student:		DOB:		Age:	

Pre-Seizure Observation/Possible Triggers:

Seizure Activity Observation:					
Demeanor			Body		
• Abnormal/Confused Speech	<input type="checkbox"/> Yes	<input type="checkbox"/> No	• Rigid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Aware/Oriented	<input type="checkbox"/> Yes	<input type="checkbox"/> No	• Fell down	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Loss of Consciousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	• Shaking/Jerking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head			• Wandering		
• Abnormal movement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	• Rocking		
Eyes			Arms		
• Turned R or L	<input type="checkbox"/> Yes	<input type="checkbox"/> No	• Jerking/Shaking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Turned up or down	<input type="checkbox"/> Yes	<input type="checkbox"/> No	• Random Movements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Staring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Legs		
• Fluttering/twitching	<input type="checkbox"/> Yes	<input type="checkbox"/> No	• Jerking/Shaking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mouth			• Random Movements		
• Smacking/Chewing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bowel/Bladder		
• Twitching	<input type="checkbox"/> Yes	<input type="checkbox"/> No	• Incontinent		
• Pulled to one side	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other		
Breathing			• Bluish coloring		
• Labored	<input type="checkbox"/> Yes	<input type="checkbox"/> No	• Pale		
• Gasping/Stopped	<input type="checkbox"/> Yes	<input type="checkbox"/> No	• Flushed		
Other:					

Post Seizure Observation					
Confused	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleepy/Tired	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Slurred Speech	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other:					

Action Taken:

- | | |
|---|---|
| <input type="checkbox"/> Sent to school nurse | <input type="checkbox"/> Doctor's Appointment Advised |
| <input type="checkbox"/> 911 Called: Time _____ | <input type="checkbox"/> Parent/Guardian Called: Time _____ |
| <input type="checkbox"/> Student transported to ER by ambulance | <input type="checkbox"/> Sent Home |
| <input type="checkbox"/> ER/Urgent Care Advised | <input type="checkbox"/> No Treatment |
| | <input type="checkbox"/> Medication (see below) |

First Aid Treatment (describe):

Medication Administration

- Diastat Midazolam Other: _____
- Time of Administration: _____
 - Dose: _____
 - Route: _____
 - Location of where it was administered: Health Room Other: _____
 - Administered by: _____

Staff Providing Assistance:

Student was sent to: Class at _____ (time) Home at _____ (time) Medical Follow up Advised

PARENT NOTIFICATION *This form must be sent home with student on the same day as event.*

Who was contacted: _____ Date: _____ Time: _____

Reporting Person: _____ Title: _____

Date: 8.18