Seizure Observation Record

Student's Name_____DOB_____

Date					
Time seizure started					
Time seizure ended					
Check all that apply					
Administer Diastat if ordered Note time given					
Alert					
Unresponsive					
Staring spells/dazed look					
Head dropping					
Eyes rolled upward					
Rapid blinking/eye fluttering					
Rocking					
Mood/behavior changes					
Body rigidity and jerking of arm/leg					
Interruption of normal breathing					
Soiling/wetting clothes					
Skin color: Bluish					
Pale					
Flushed					
Tongue biting					
Mouth movements					
Drooling					
Verbal sounds (gagging, talking, throat clearing, etc.)					
Post Seizure: Normal breathing					
Difficulty breathing					
Alert					
Confused					
Sleepy/tired					
Headache					
Slurred speech					
Injuries? If yes, record on back.	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Parents notified?					
EMS called?					
Observer's Name					
Copy of seizure report to school nurse					

Student Name_____

Narrative:_____