

## 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.*