East Central Catholic Schools

SEIZURE OBSERVATION AND RECORD

Name:_____ Grade:_____ Date:_____

Observer:_____ Position:_____ Date:_____

Before the Seizure

1. Did you see the onset of the seizure? Yes☐ No☐
2. Or did someone alert you? Yes☐ No☐
3. Where was the student?_____
4. What was he/she doing?_____
5. Did he/she Cry or yell ☐ Fall down ☐ Stare☐ Other_____
6. Did he/she notice any of these auras? Smell☐ Sound☐ Visual ☐
   Have strange sensations in the stomach ☐ Other_____

   Additional Comments_____

During the Seizure

1. Did he/she have convulsions? Yes☐ No☐
2. Which parts of the body were involved?_____
3. How long did the seizure last? Minutes☐ Seconds☐
4. Did he/she Wander around ☐ Stare ☐ Fall ☐ Pick at clothes/body ☐
   Have mouth movement ☐
5. Did he/she Talk clearly ☐ Mumble ☐ Slur ☐ No Speech ☐
6. On which side of the body did the seizure start? Right ☐ Left ☐ Both☐ Unknown ☐
7. Did he/she drool during the seizure? A little ☐ A lot ☐ None ☐
   Excess swallowing ☐
8. What was his her level of consciousness? Unconscious ☐ Dazed ☐ Alert ☐
9. Did he/she have a loss of bodily control? Bladder ☐ Bowel ☐ Both ☐ Neither ☐
10. Watch his/her:
    a. Breathing Impaired ☐ Absent ☐
    b. Head or face twitching or grimacing ☐
    c. Eyes rolling To the right and left ☐ Upwards ☐ Downwards ☐
    d. Arms and legs Rigid or jerking ☐ Equal & Rhythmic ☐ Extended & flexing ☐
    e. Skin tone Pale ☐ Blue/grey ☐ Cool ☐ Warm ☐ Clammy ☐

Additional comments:_____

After the Seizure

1. Was the student injured? If yes, please describe

   _____

   _____
2. Does he/she have a headache? Yes ☐ No ☐
3. Can he/she recall the seizure? Yes ☐ No ☐
4. Does he/she appear: Alert ☐ Drowsy ☐ Confused ☐

5. Is there muscle tiredness or weakness specific to one site? Yes ☐ No ☐
   If yes, where?_____
6. Does he/she feel Sleepy ☐ Weak ☐
7. If sleepy, how long did/he she sleep post seizure?_____
   Additional Comments