



Seizure Event

(Once completed, please upload to student's file)

Student Name: _____ Date: _____

Seizure start time: _____ Seizure end time: _____

Was medication administered: ___ Yes ___ No VNS magnet used: ___ Yes ___ No

If medication was administered or VNS magnet used, note time(s): _____

Response: _____

Medication given: Diastat rectal gel: _____ Intranasal: _____ Other: _____

Was 911 called: ___ Yes ___ No Nurse Notified: ___ Yes: Time: _____

Parent Notification

Name of parent: _____ Time notified: _____

Comments: _____

Before seizure event

What was the student doing prior to the seizure: _____

Were any possible triggers present: _____

During the seizure

Facial expression: ___ Staring ___ Twitching ___ Eyes Rolling ___ Eyes Blinking ___ Other

Head Movements: ___ Sudden head drop ___ Turns to 1-side ___ Turns side to side

Body Stiffness: ___ Whole Body ___ Legs ___ Arms

Jerking Movements: ___ Whole body ___ Legs ___ Arms ___ None

Speech: ___ Able to talk normally ___ Unable to talk ___ Incoherent/Nonsense words

___ Mixing up words

Did the student fall: ___ Yes ___ No If yes, list injuries: _____

Other observations: _____

After Seizure (Please check all that apply)

___ Fully aware ___ Responds Normally ___ Confused ___ Tired ___ Asleep

___ Agitated/Irritable ___ Other: _____

___ Injury (if yes, please indicate what interventions were taken): _____

Post seizure actions/comments: _____

Name of Observer: _____ Date: _____

Signature: _____