Holly Area Schools

Seizure Event

Once completed please place original in student yearly file, a copy to the parent and district nurse

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

After Seizure (Please check all that apply)

__ Fully aware __ Responds Normally __ Confused __ Tired __ Asleep
__ Agitated/Irritable __ Other: _____
__ Injury (if yes, please indicate and what interventions taken):_____
_____
Post seizure actions/comments: _____
_____
Name of Observer: _____ Date: _____
Signature: _____

4/2022