Clarksville-Montgomery County School System

SEIZURE RECORD

Purpose: To help you manage and keep track of seizures as they occur and record any pre-seizure and post-seizure activity.

How to use: After being completed, a copy should be sent home for the parent / guardian records.

Note: Use only 1 form per seizure. Duplicate as needed.

STUDENT'S NAME _____ **Date of Report** _____

EVENT	TIME
SEIZURE START TIME	
DIASTAT RECTAL GEL ADMINISTRATION TIME ** IF PRESCRIBED BY PHYSICIAN**	
VNS (vagal nerve stimulator) magnet **IF PRESCRIBED BY PHYSICIAN**	
Other Treatments ** IF PRESCRIBED BY PHYSICIAN**	
911 CALLED **IF NEEDED**	
SEIZURE END TIME	

Where was the child when the seizure occurred?

_____

_____

_____

Activities immediately preceding the seizure-

_____

_____

_____

Noteworthy behavior immediately preceding the seizure-

_____

_____

_____

Description of seizure behavior-

_____

_____

_____

Behavior after the seizure-

_____

_____

_____

Where there any injuries? _____YES _____NO

If yes, please describe-

_____

_____

_____

_____

Comments_____

_____

_____

AFTER THE SEIZURE

Check any side effects you may have observed and add relevant details:

Drowsiness____ Slurred Speech____ Irritability____ Nausea____

Confusion____ Unsteady walk____ Inattention____ Poor memory____

Comments_____

_____

_____

_____ _____

Signature of person to witness seizure **Date**