### SEIZURE RECORD

**STUDENT’S NAME DATE**

**CLASSROOM TIME OF OCCURRENCE**

**PRECEDING CONDITIONS:**

 **Student’s Location Student’s Activity**

**Warning Signs No Yes If “Yes” describe**

**SEIZURE BEHAVIOR:**

Duration (if approximate, state it)

Did student’s body stiffen? No Yes

Did student’s body shake? No Yes

Parts of body involved

Did student fall? No Yes

Any apparent injury? No Yes

Describe

Did the student receive a bump or blow to the head? No \_\_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\****Consider consulting with student’s Health Care Provider on any Bump or Blow to the Head*.**

Did student appear to become unaware of the environment? No Yes

Was there a change in color of the student’s lips, nail beds, etc? No Yes

Describe

Did student wet or soil? - - - - - - - - - -- - - - - - - - - - - - - - Urine No Yes

Feces No Yes

Did student have difficulty breathing? - - - - - - - - - - - - - - Before No Yes

 During No Yes

 After No Yes

Other

**Follow-up:**

Describe First Aid given:

Describe student’s activity after seizure

Original Copy to Parent/Guardian: [ ] Yes

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