Everett Public Schools
Health Services

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

Reported by _____

Seizure Record
Effective: 7-01, 4/03, 5/04, 1/08