The Seizure Observation Record provides a guided, detailed format to keep track of a person's seizures. This form can be used by any observer including parents, family members, caregivers, teachers, coaches, etc.

SEIZURE OBSERVATION RECORD

Student Name: _____

	Seizure #1	Seizure #2	Seizure #3
Observer's Name:			
Date & Time:			

Pre-seizure observations:			
List & describe behaviors, triggers, activities, etc.:			
Awake when seizure started? (yes/no/altered)			

Sensations Experienced by Person: Please Circle **Yes** or **No**

Feeling that something has already happened	Yes	No	Yes	No	Yes	No
"Funny" taste in the mouth	Yes	No	Yes	No	Yes	No
"Funny feeling in the stomach	Yes	No	Yes	No	Yes	No
Changes in vision (blurriness, etc.)	Yes	No	Yes	No	Yes	No
Changes in hearing	Yes	No	Yes	No	Yes	No
Strange or surprising smells	Yes	No	Yes	No	Yes	No

Muscle Tone/Body Movement: Please Circle **Yes** or **No**

Rigid/Clenching	Yes	No	Yes	No	Yes	No
Limp	Yes	No	Yes	No	Yes	No
Fell Down	Yes	No	Yes	No	Yes	No
Rocking	Yes	No	Yes	No	Yes	No
Wandering Around	Yes	No	Yes	No	Yes	No
Whole Body Jerking	Yes	No	Yes	No	Yes	No

Extremity Movements: Please Circle **Yes** or **No**

Right Arm Jerking	Yes	No	Yes	No	Yes	No
Left Arm Jerking	Yes	No	Yes	No	Yes	No
Right Leg Jerking	Yes	No	Yes	No	Yes	No
Left leg Jerking	Yes	No	Yes	No	Yes	No
Random Arm/Leg Movement	Yes	No	Yes	No	Yes	No

Color: Please Circle **Yes** or **No**

Bluish	Yes	No	Yes	No	Yes	No
Pale	Yes	No	Yes	No	Yes	No
Flushed	Yes	No	Yes	No	Yes	No

Eyes: Please Circle **Yes** or **No**

Pupil Dilated	Yes	No	Yes	No	Yes	No
Turned to One Side (R of L)	Yes	No	Yes	No	Yes	No
Rolled up/Not visible	Yes	No	Yes	No	Yes	No
Staring or Blinking	Yes	No	Yes	No	Yes	No
Closed	Yes	No	Yes	No	Yes	No

Mouth: Please Circle **Yes** or **No**

Salivating	Yes	No	Yes	No	Yes	No
Chewing	Yes	No	Yes	No	Yes	No
Lip-Smacking	Yes	No	Yes	No	Yes	No

Other Symptoms (Please Describe):

Verbal Sounds: (Gagging, talking, throat clearing)			
Breathing: (Normal, heavy, stopped, noisy, etc.)			
Incontinence: (Urine or feces)			

Post-Seizure Observation: Please Circle **Yes** or **No**

Confused	Yes	No	Yes	No	Yes	No
Sleepy/Tired	Yes	No	Yes	No	Yes	No
Headache	Yes	No	Yes	No	Yes	No
Slurred Speech	Yes	No	Yes	No	Yes	No
Other (please describe)						

Seizure Length:			
Time until full awareness post-seizure:			
Injuries sustained during seizure: (briefly describe)			
Parents/Guardian Notified: (Time of call)			
District Nurse Notified: (Time of call)			
EMS called: (Time of call & arrival time)			