SEIZURE REPORT

Name:_____ Date of seizure:_____

Time seizure began:_____ Duration:_____ ❑ Estimate ❑ Actual

Observations prior to seizure: _____

_____

_____

_____

Describe seizure in detail: _____

_____

_____

PHYSICAL SIGNS:

Loss of bowel control? ❑ Yes ❑ No Loss of bladder control? ❑ Yes ❑ No

Describe their breathing: _____

Skin color: _____

Conscious during seizure: ❑ Yes ❑ No

Responsive during seizure: ❑ Yes ❑ No

Comments:_____

Responsiveness and behaviour after seizure (e.g. to name, surroundings, memory of seizure, activities): _____

_____

Medical attention required: ❑ Yes ❑ No Time & Date _____

Concerns/comments _____

_____

_____

People involved:_____

(Note: If seizure activity is unusual or requires medical attention, contact direct supervisor)

People contacted (e.g. Doctor, Supervisor, Guardian, etc.)

NAME	TIME	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Recorded by: _____ Date: _____

Team Manager: _____ Date: _____

Coordinator: _____ Date: _____